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Version: Version of Record

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**FAMILY PERSPECTIVES ON BED WETTING
IN YOUNG PEOPLE**

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**A thesis submitted in
partial fulfilment of the
requirements of the Open University
for the degree of
Doctor of Philosophy
in the discipline of Nursing**

*Date of submission: November 1995
Date of award: 21 December 1995*

**QUEEN MARGARET COLLEGE
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ACKNOWLEDGEMENTS

This study and this account of it have been made possible by the goodwill, help and encouragement of many people. Special thanks are due to the families who shared their experiences and feelings with me over several occasions. It has been a privilege and an honour to have Lisbeth Hockey as a supervisor. She is the best teacher that I have ever known. My thanks also to Phil Runciman (Director of Studies) and Francine Cheater for their helpful comments. I felt that I had the moral support of all my colleagues in the Department of Health and Nursing at Queen Margaret College. The college librarians, headed by Penny Aitken, rendered me an unfailingly excellent service. A grant of £2,500 towards the study's costs from the Coloplast Charitable Trust is gratefully acknowledged. Particular thanks are due to my husband Graeme and my parents-in-law Helen and Alastair who have lived with this study for 3 years and helped in innumerable ways. They have cheerfully and tirelessly typed this thesis, which has been revised many times, and they have learned new computing skills to facilitate its presentation. Helen Morison and Valerie Chuter willingly undertook the onerous task of conversation transcription. I have received helpful comments and support from so many staff within Forth Valley Health Board, including: James Kennedy (Director of Planning and Development and Chief Nursing Advisor); Carole Morrison (Acting Director of Quality) and Irene Linton (Clinical Director, Community Health Directorate, Central Scotland Health Care NHS Trust). I am particularly grateful to the health visitors who helped with the enrolment of the families and shared their experiences of helping families with a bed wetting child, and to the members of the GP Research Group (now Primary Care Research Group) who offered constructive comments on the study's design and on the contents of the supplementary data collection tools. The help of George McKelvie with the design and analysis of the urinary symptoms questionnaire and his comments on the study's findings, from an urologist's perspective, are gratefully acknowledged. My thanks also go to Dorothy Whyte for introducing me to the family systems nursing literature. Last, but by no means least, I would like to thank Cristobel Simpson (formerly Acting Director of Nursing Services, Stirling Royal Infirmary) who encouraged me to leave a job I loved, to spread my wings and to seek new horizons. To all those who have helped me, in whatever ways, my warmest thanks and heartfelt appreciation.

ABSTRACT

The aim of this study was to explore the nature and experience of bed wetting from the perspective of young people who wet the bed, and that of their parents and siblings. A review of the literature suggested that there was still much to be learned about how families manage a young person's bed wetting in the context of every day family life. A qualitative, inductive approach and grounded theory generating methods were used. Nineteen families and twenty young people aged 4 to 17 years, living in some of the most deprived as well as the most affluent localities in the study area, took part. Analysis of in-depth unstructured conversations was facilitated by NUD•IST Power Version 3.0 computer software. With the aid of memos, logic diagrams and a coding paradigm (axial coding) the relationships between emergent concepts were identified and tested and a grounded theory developed around the core concept of "perceived control", which often manifested as "perceived helplessness". The data help to explain how parents' and young people's attitudes towards bed wetting may be reinforced as they interact from day to day. The study has revealed many insights into family processes and the roles played by individual family members, including fathers and siblings. The social consequences of bed wetting are described. Several conditions have been identified which, it is strongly suggested by the data, may need to be fulfilled for the young person to have the best chance of becoming reliably dry at night, using conventional treatment methods. Families' experiences of methods suggested by health care professionals have important implications for practice. It is argued that the family, rather than the individual or the mother-child dyad, should be the unit of intervention. Ways of enhancing a belief in competence among young people, their parents and health care professionals are described.

If a child lives with criticism
He learns to condemn
If a child lives with hostility
He learns to fight
If a child lives with ridicule
He learns to be shy
If a child lives with shame
He learns to feel guilty
If a child lives with tolerance
He learns to be patient
If a child lives with encouragement
He learns confidence
If a child lives with praise
He learns to appreciate
If a child lives with fairness
He learns justice
If a child lives with security
He learns to have faith
If a child lives with approval
He learns to like himself
If a child lives with acceptance and friendship
He learns to find love in the world.

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CHAPTER 1: AN OVERVIEW OF THE STUDY

1.0 Introduction

This introductory chapter gives an overview of this study by describing the nature of bed wetting and the involvement of health care professionals, the origins of the study, the initial research questions and the approach adopted to answering them.

1.1 The nature of bed wetting and the involvement of health care professionals

"No other complaint (bed wetting) has given rise to so many treatment endeavours and such dispute as to its pathogenesis and whether it can properly be characterised as a disease or not. Treatment ranges from ritual procedures to modern medical treatment with a solid scientific basis. Some specialists consider the complaint to be a variation of normality, whereas others regard it as a disease. Regardless of whether one subscribes to one opinion or the other, modern urbanised life puts demands on children at an early age to be able to control continence in order to comply socially."

Djurhuus, Norgaard and Rittig (1992) p.8

Bed wetting is a phenomenon surrounded by both mystery and controversy. It has been described as a benign, self-limiting pathology whose natural course (to dryness) can be accelerated by treatment and as a social construct, that is as deviance from socially accepted norms regarding the age at which a child should be reliably dry at night (Section 2.2.1). In the latter approach a bed wetting child is defined not so much as having a pathophysiological problem but as failing to meet society's expectations of the age of attainment of a normal developmental milestone.

In recent times, the cause of bed wetting has been variously attributed to reduced bladder capacity, unstable bladder contractions, bladder outlet disturbances, sleep disorders, urine output regulation dysfunction or psychological problems. The focus of much clinical research has been on bladder function and there have been many clinical trials of interventions which are based on the belief that bed wetting is a pathophysiological problem (Section 2.2.3).

The interventions have included pharmacologically reducing the rate and volume of urine production overnight, pharmacotherapy aimed at reducing unstable bladder contractions and various surgical interventions to correct supposed bladder outlet disturbances. Successful treatment with the antidiuretic hormone arginine vasopressin (AVP) suggests that night time polyuria and AVP deficiency may contribute to bed wetting but many other therapeutic approaches still in use are said to be of questionable efficacy (Wille, 1994).

There is a growing body of evidence that bed wetting involves a normal, complete micturition which can occur at any stage in the sleep cycle, in young people who are psychologically normal and who have a normal bladder capacity (where the bed wetting is monosymptomatic). There is, however, some evidence that the bed wetting child's arousal response to a full bladder may be underdeveloped or malfunctioning.

Over the last 50 years one of the most successful treatment approaches for monosymptomatic bed wetters has been behavioural training using a bedside or body worn alarm (Forsythe and Butler, 1989). The rationale behind this method is that the young person needs to learn to wake up to the physiological signals that the bladder is full.

An organic cause for bed wetting, such as a congenital abnormality or a neurological disorder, has only been identified in a very small percentage of cases (Norgaard, 1991). The aetiology of bed wetting for the majority of monosymptomatic bed wetters is almost certainly multifactorial and it is still a matter of considerable debate.

At the heart of the controversy is the very practical question: "Whose business is it?" Many professionals regard the treatment of bed wetting as being within their remit, including urologists, paediatricians, clinical psychologists, general practitioners (GPs) and nurses. In the first instance parents may seek help from their GP or their health visitor. In other cases the health visitor may discover the young person's bed wetting at a pre-school check or when visiting the family at home for another purpose, or it may be discovered by the school nurse. After ruling out obvious congenital abnormalities, neurological disorders or other possible causes such as repeated urinary tract

infections, the GP may refer the young person to a paediatrician, a clinical psychologist or a urologist for a specialist opinion. Urologists describe bed wetting as the most common "urological" complaint in children (Djurhuus et al, 1992), yet there is no consensus among them or among paediatricians or clinical psychologists about how to treat it (Section 2.2.3). The diversity of treatment approaches in current use seems to add to the uncertainty of what it is that is actually being treated.

While many health care professionals may become involved with some families at one time or another in the search for a solution to the young person's bed wetting, there is evidence that many families rarely if ever actively seek help from any health care professional (Devlin, 1991; Foxman et al, 1986).

There is, however, evidence that bed wetting is a common problem. Epidemiological surveys suggest that 15 - 20% of five year olds, 5% of ten year olds and 1 - 2% of fifteen year olds and over wet the bed regularly. It has been estimated that 500,000 young people in the UK wet the bed on some occasions (Blackwell, 1995) (Section 2.2.2) yet the problem is, for the most part, hidden and many sufferers believe themselves to be alone.

There is a growing body of anecdotal evidence, collected by community based nurses and clinical psychologists running specialist enuresis clinics, that both the young person and the family feel embarrassment at the young person's failure to attain a developmental milestone which the majority of children attain between the ages of three and four years. These anecdotal accounts suggest that bed wetting can have far reaching consequences for the young person and the family (Section 2.2.4).

As bed wetting is for the most part managed by the family, within the context of every day family life, it would seem that an understanding of how families experience and respond to a young person's bed wetting, and their experience of methods suggested by health care professionals, could have important implications for both service organisation and service delivery.

Because of the nature of her relationship with families, and her long term involvement with families over time (in an ideal world) the health visitor is particularly well placed to understand the attitudes of individuals within the family to the young person's bed wetting, the family's dynamics, the family's material circumstances and access to resources, and the family's special problems and needs, at a particular point in time. These are all part of the context in which bed wetting is managed from day to day.

The health visitor is the health care professional most likely to discover the family's "secret" and to be in a position to give practical advice and support to the family as a whole. There is little doubt that long-term support of the family will be required, until the young person becomes reliably dry.

Health care professionals suggest that bed wetting, unlike chronic diseases of childhood such as spina bifida, cystic fibrosis, asthma and diabetes mellitus (Eiser, 1993), is both non-life threatening and curable. Yet even when a family has been selected for inclusion in a clinical trial of an established treatment, such as a body worn alarm, and is given clear information, and is supported and followed up according to a carefully devised protocol, the young person's success in achieving dry nights for six months or more cannot be guaranteed (Forsythe and Butler, 1989).

It has been suggested that treatment based on an alarm should not be considered to have failed until it has been trialled for at least 16 weeks without the young person achieving 14 consecutive dry nights (Butler, 1991). The co-operation of the parents and the young person over such a prolonged period is an obvious pre-requisite for success.

Other than anecdotal accounts, little is known of families' experiences with methods suggested by health care professionals in the home setting, when a clinical trial protocol is not in use, or of how long families persist with the regimes suggested.

While the roles of the paediatrician, the urologist and the clinical psychologist are not to be underestimated, it would seem that for the majority of monosymptomatic bed wetters the health visitor has the most pivotal role to play in assessing the young person and the family, in acting as

gatekeeper to more specialist services, and in supporting the whole family in what may be a long haul to a completely successful outcome.

It is suggested that the family's experience of bed wetting is a particularly appropriate topic for a nurse to research as working with families is very much a nurse's business (Wright and Leahey, 1993). Whall's (1993) historical review of the family as the unit of care in nursing suggests that this has always been so, although the understanding of the concept of family nursing and its implications for nursing practice is still evolving (Friedmann, 1993; Bell, 1995; Taylor, 1995).

The serendipitous way in which the research topic came to be chosen is described below.

1.2 The origins of the study

(This section outlines the personal origins of this study. It has therefore been written in the first person.)

My particular interest in urinary tract dysfunction and urinary incontinence began when, as Research and Audit Sister in a District General Hospital, I became involved in an audit of prostatectomy (McKelvie et al, 1992). From my earliest conversations with mostly elderly patients I was struck by the far-reaching consequences of benign prostatic hyperplasia (BPH) for the men's activities of daily living and social functioning. I also became convinced that in addition to collecting mortality and morbidity data we should address issues relating to quality of life when measuring the outcome of surgery.

Following an extensive review of the literature (including the work of Fowler et al, 1988; Wyman et al, 1990 and Yu, 1989) I began to construct an abbreviated quality of life measuring instrument, specific to male urinary symptoms, for use both in hospital and the community. This work was overtaken by the development of a BPH Symptom Index by the American Urological Association (AUA) (O'Leary et al, 1992; Barry et al, 1992a,b) which included questions relating to quality of life specific to this condition.

With the purpose of learning more about different research methods and a growing curiosity about quality of life in relation to urinary incontinence I applied for and was awarded a studentship entitled: "The psychological and social effects of urinary incontinence: individual, family and carer perspectives".

While reviewing the literature on informal carers I became interested in the consequences of caring for the carer, through reading such works as Parker's (1993) book on caring and disability in marriage, Twigg's (1992) review of research relating to informal carers and Glendinning's (1992) book *The Costs of Informal Care: Looking Inside the Household*.

I had originally intended to explore the psychosocial effects of urinary incontinence in the elderly when a chance encounter in the changing rooms of a swimming pool caused me to change the focus of my study to the consequences of bed wetting for young people and their families. A lady whom I knew only by sight asked me what I did for a living. When I told her that I was a nurse about to embark on a study of the impact of urinary incontinence in the elderly and their carers, she suggested that I look instead at the problem of bed wetting in children. She told me that her 16 year old son had never been dry at night and that at times she was at her wits' end. She described it as "hell".

This chance encounter made me wonder whether all mothers of a bed wetting child felt as despairing as this mother seemed to be. I had never worked as a nurse in the community (other than for one month during my training) and I had no experience of bed wetting either personally or professionally, but as I drove home I knew that the impact of bed wetting on young people and their families would be the focus of my study and it is a decision which I have never regretted.

1.3 The initial research questions and the approach taken

Following the encounter with the mother of a bed wetting adolescent (Section 1.2) it was decided that the topic for this study would be the experience and meaning of bed wetting for young people aged 5 to 20 years, and their families. A review of the literature confirmed that there was a great deal still to

learn about how bed wetting is managed in the context of every day family life and its impact for everyone in the family (Chapter 2).

Two broad research questions were initially framed:

1. How do parents and young people manage the practical consequences of bed wetting from day to day?
2. What impact do young people and their parents perceive bed wetting to have on the quality of their lives as individuals and on the quality of family life?

To seek answers to these questions a qualitative research approach, an inductive process of inquiry and grounded theory generating methods were selected (Chapter 3).

The initial research questions were developed in the knowledge that they might be refined or even abandoned early on in the study, in the light of themes emerging from the data during ongoing analysis. The refinement of the initial research questions rapidly took the emphasis of the study beyond a descriptive understanding of the meaning of the experience of bed wetting, from the perspective of individual family members, towards a new understanding of the processes going on within families and a conceptualisation of the family as a unique, multi-generational social system.

1.4 An overview of the thesis

The material in this thesis is arranged in seven chapters. The present introductory chapter provides a brief overview of the study. Chapter 2 summarises the findings of the literature review undertaken before and during the early stages of data collection. Chapter 3 outlines and justifies the study's design and methods. Chapter 4 sets the scene for the remaining chapters by summarising contextual data about the families enrolled into the study. Chapter 5 seeks to answer the initial broad research questions by describing the families' experiences of living with a young person who wets the bed. It includes accounts of the part played by different family members in the management of the young person's bed wetting, the social consequences of bed wetting for individual family members and for the family as a social unit and the families' experiences of treatment methods suggested by health

care professionals. Chapter 6 describes the beliefs and attitudes of family members to bed wetting and explores the relationship between beliefs, feelings and behaviour as family members interact with one another from day to day. This chapter includes an analysis of the concepts of perceived helplessness and perceived control. Chapter 7 outlines the implications of this study's findings for practice and indicates some directions for further research.

CHAPTER 2: THE LITERATURE REVIEW

2.0 Introduction

This chapter begins by discussing the uses of literature in qualitative research (Section 2.1). Section 2.2 summarises the findings of a literature review on bed wetting. It includes a discussion of the nature of bed wetting and its prevalence, the management of bed wetting by families and by health care professionals and the impact of bed wetting on the individual and the family. Section 2.3 reviews the literature on the nature of the family and the dynamics of the interaction of family members. The chapter ends by highlighting some unanswered questions about bed wetting and its management which are of particular relevance to this study (Section 2.4).

2.1 The uses of literature in qualitative research

The researcher came to this study with no professional or personal experience of bed wetting, no professional experience of working with families in the community setting, and with only a rudimentary knowledge of qualitative research methods (Section 1.2). These acknowledged deficits necessitated a period of library work to find out what was known about the research topic (Section 2.2), to aid the identification and delineation of the research problem and the initial research questions (Section 3.1) and to gain a thorough understanding of qualitative research methods and their underlying assumptions.

When conducting research using quantitative methods it is usual to conduct an exhaustive review of the literature at the start of a study. This is undertaken to identify gaps in existing knowledge, to identify the variables relevant to the research questions, to generate hypotheses for testing and to suggest a conceptual framework to guide the research and to facilitate the interpretation of data.

In qualitative research, the literature is used somewhat differently. As in quantitative research, a review of the literature can greatly facilitate the identification and delineation of the research problem and help to confirm the appropriateness of the approach proposed. An awareness of the

literature can also be useful in many other ways: facilitating initial, selective sampling (Section 3.6.1); stimulating questions during ongoing data analysis (Section 3.9), and acting as a secondary data source (Glaser, 1978; Silverman, 1985; Strauss and Corbin, 1990). However, commitment to *a priori* knowledge, including knowledge of existing conceptual frameworks, can jeopardise the research process by stifling creativity and can seriously threaten the validity of the study's findings (Morse, 1992a).

It is easy for the qualitative researcher to feel that knowledge is dangerous but from a pragmatic viewpoint the possession of knowledge as a result of previous experience in the field is often unavoidable, whether this is gained as a researcher or through professional practice. Strauss and Corbin (1990) suggest that existing knowledge should not be ignored and that all types of literature judged to be relevant to a study can and should be used at any and every stage of the research process. The danger of knowledge is not in possessing it but in becoming a captive of it (Strauss and Corbin, 1990; and Morse, 1992a). The literature on bed wetting was reviewed with these principles in mind (Section 2.2).

From the earliest contacts with the families, asking the question: "What is going on here?" raised many questions about family dynamics and the consequences of the interactions between family members from day to day. These questions naturally led to an exploration of the literature on the family, with a special emphasis on understanding family processes (Section 2.3.2). The literature on family systems theory, reviewed in Section 2.3, was found to be entirely congruent with the principle of mutual simultaneous shaping, one of the central axioms of the naturalist paradigm, which formed the basis of this study's research approach (Section 3.1). Through reading the family systems literature the researcher was sensitised to the mutual interplay of family members. The theory which has resulted from this study emphasises dynamic family processes (Chapters 6 and 7).

As new themes emerged during data analysis the researcher returned to the literature on occasion to see whether a particular theme, identified from the data, had been identified by others and if so what they had said about it. The findings from the literature were used in a constant comparative way to

gain insight into the theme being explored. In this way the reading was truly grounded in the data. Two examples illustrate this approach to the use of literature.

"Mother as orchestrator" was identified from the data as a major theme at an early stage in the study (Section 5.2.1). A review of the literature on parents' roles in child care was then undertaken and helped to set the family's experience of bed wetting and its management within the context of the parents' roles in child care more generally (Sections 5.1 and 5.2).

The literature was turned to again, much later in the study, in order to gain further understanding of the relationship between beliefs, feelings and behaviour (Section 6.2.2.1). A large body of literature on social cognition was discovered. Reviewing this literature led to a greater understanding of the influence of beliefs about bed wetting on both attitudes and behaviour as family members interacted with one another from day to day.

In a more prosaic way the literature on bed wetting sensitised the researcher to the methods that might be found to be in use by the families. A review of the literature on bed wetting also uncovered a more fundamental issue regarding the uncertainty among health care professionals about the aetiology of bed wetting and whether it can be characterised as a pathology or not (Section 2.2).

2.2 Bed wetting

2.2.0 Introduction

"Many times ... as well old men as children, are oftentimes annoied, wha their urine issueth out either in their slepe or waking against their willes, havi(n)g no power to reteine it whan it cometh ..."

Phaire (1553/1957) p.53

This section summarises the findings of the initial literature review of bed wetting undertaken to gain an overview of what was known about the topic and to aid the identification and delineation of the research problem and the initial research questions.

Two contrasting perspectives on the aetiology of bed wetting were discovered and are discussed in Section 2.2.1. The epidemiology of bed wetting is reviewed in Section 2.2.2. Approaches to the management of bed wetting are described in Section 2.2.3, from the health care professional's perspective and the families' perspective. The literature on the impact of bed wetting on the individual and the family is discussed in Section 2.2.4.

2.2.1 Perspectives on bed wetting

Bed wetting is a phenomenon whose cause is uncertain. Even in recent times it has been attributed to reduced bladder capacity, unstable bladder contractions, bladder outlet disturbances, sleep disorders, urine output regulation dysfunction or psychological problems. An organic cause for bed wetting, such as a congenital abnormality or a neurogenic disorder, has only been identified in a very small percentage of cases (Norgaard, 1991). The aetiology of bed wetting for the majority of bed wetters is still a matter of considerable controversy within the medical profession, and between health care professionals and social scientists more generally and it is almost certainly multifactorial.

A review of the literature on bed wetting, undertaken before contact was made with families, uncovered two contrasting perspectives. In the medical literature bed wetting is often described as a benign self-limiting pathology whose natural course (to dryness) can be accelerated by treatment. A contrasting perspective is to describe bed wetting as a social construct - that is, as deviance from socially accepted norms regarding the age at which a young person should be reliably dry at night (Leenders, 1993). In the latter approach, a bed wetting child is defined not so much as having a pathophysiological problem but as failing to meet society's expectations of the age of attainment of a normal developmental milestone. In practice many health care professionals straddle these contrasting perspectives by defining bed wetting in socio-medical terms.

The perspective brought to bed wetting by different professionals working with families to help to resolve the problem can influence how bed wetting is defined and can have important implications in practice. Beliefs about the cause of bed wetting can certainly influence the treatment prescribed (Section 2.2.3). Whether health care professionals acknowledge and are prepared to address the

social and emotional consequences of bed wetting for the child and his or her family, or merely regard bed wetting as a benign self-limiting condition, can affect both the professional's attitude to the family and how seriously and quickly a solution is sought. A study by Shelov et al (1981) suggests that parents expect their child to be dry at night at about the time that most children normally achieve dryness (between the ages of three and four years). They become concerned about bed wetting from then on, while most doctors do not define bed wetting as a problem until the child is considerably older than this. Clinicians may defer treatment until the child is seven years of age (or even older), believing that by this time the situation will have resolved itself in most cases (Butler, 1993a).

Bed wetting as a benign self-limiting pathology

Bed wetting is often described as the most common urological complaint in children (Djurhuus et al 1992). Looked at from a medical perspective, bed wetting is generally not now regarded as a distinct disease or disorder but as a symptom (Vereecken, 1990).

Monosymptomatic bed wetting is not generally regarded as a sign of bladder dysfunction, but where bed wetting is accompanied by day wetting, neurogenic disorders, lower urinary tract dysfunction and congenital malformation need to be ruled out, when the child is being assessed. The present section is confined to a discussion of monosymptomatic bed wetting where the cause is far from certain.

Children are born unable to control bladder emptying voluntarily. The acquisition of continence is said to be a complex skill which occurs early in childhood (Cheater, 1992) and which probably involves both spontaneous physiological maturation and the learning of certain associated social skills (Smith & Smith, 1987a, b). The dilemma, even for those health care professionals who adopt a socio-medical perspective, is to decide on the point at which wetting the bed becomes abnormal. The ways in which some health care professionals and researchers have defined urinary incontinence in childhood, and bed wetting in particular are now discussed, in this context.

Definitions of bed wetting

Some confusion has arisen because there are different uses of the terms enuresis, urinary incontinence and bed wetting in the literature which may be a reflection of the different perspectives on bed wetting amongst the different professionals involved with families in its management.

The International Continence Society's (ICS) Committee on Standardisation of Terminology defined enuresis as any involuntary loss of urine and proposed that if it is used to denote incontinence during sleep, enuresis should always be qualified with the adjective "nocturnal" (Abrams et al, 1988, p.17). Hjälmås (1992) suggests that the term enuresis should only be used to denote complete micturitions and should be reserved for bed wetting and for "giggle" enuresis. Throughout this study the terms "nocturnal enuresis" and "bed wetting" are used interchangeably to denote complete involuntary micturitions during sleep.

Acknowledgement of the social component of bed wetting is contained in the ICS definition of urinary incontinence as:

"... involuntary loss of urine which is objectively demonstrable and a social or hygienic problem."

Abrams et al (1988) p.17

This definition acknowledges that cultural values, social norms and culturally shared rules have a part to play in the interpretation of involuntary loss of urine as "a social or hygienic problem".

Children have to learn to void urine in a socially appropriate place and at a socially appropriate time, both in the day and at night (Norton, 1986).

In a treatment manual written for professionals, a psychologist and a psychiatrist defined nocturnal enuresis as:

"... persistent childhood bed wetting, which occurs in the absence of any discernible neurological or urological pathology, and which continues beyond an age by which most children, without the need for special attention, have gained normal control over functioning of the bladder."

Bollard and Nettelbeck (1989) p.1

In a book written for parents, professionals and the older bed-wetting child the Deputy Director of Social Services in Oxfordshire, who has been involved in research into enuresis since the early 1970s, defined bed wetting very similarly as:

"... persistent and frequent urination during sleep at an age at which a greater degree of night-time bladder control is considered to be normal."

Morgan (1988) p.27

These definitions beg three important questions: from what age should wetting the bed be considered to be abnormal; how frequently does bed wetting need to occur to be defined as abnormal, and who decides? There is considerable disagreement in the literature and amongst health care professionals about the answers to these questions.

Some researchers suggest that the physiological maturation needed for night time bladder control is present in children by the age of three, define bed wetting as a problem in individuals aged three and over and treat children for it from this age (Azrin, et al, 1974). Others define nocturnal enuresis as: "over age four" (Devlin, 1991) or "at or after the age of five" (e.g. Forsythe and Butler, 1989; Hjälmås, 1992).

Forsythe and Butler's (1989, p.879) definition of enuresis is:

"... involuntary discharge of urine by day or night or both, in a child aged five years or older, in the absence of congenital or acquired defects of the nervous system or urinary tract."

This is the definition used in publications originating from the Enuresis Resource and Information Centre (ERIC) at Bristol, such as their guide to enuresis, written for professionals (Blackwell, 1989, 1995) and their guidelines on minimum standards of practice in the treatment of enuresis (Morgan, 1993), which were supported by the National Enuresis Research Steering Group. Their choice of the age of five years or older as defining enuresis corresponds to Hjälmås' (1992) more general proposal to define childhood urinary incontinence as occurring from five years of age. This is why "age five or over" was originally used as one of the inclusion criteria for this study (Section 3.6.1).

Turning to the second question "how frequent does bed wetting need to be to be defined as abnormal?", frequencies quoted in the literature vary from seven nights a week to one night in six months (Jarvelin et al, 1990). Between these extremes definitions have included: "at least twice a week" (Devlin and O'Cathain, 1990); "at least once a week" (Couchells et al, 1981; Hjälmås, 1992); "at least once a month" (Devlin, 1991; Jarvelin et al, 1991; Oppel et al, 1968a) and "at least once in three months" (Foxman et al, 1986; Hellstrom et al, 1990).

In an extensive review of the pathophysiology of bed wetting Norgaard (1991, p.11) states:

"A clear-cut definition of nocturnal enuresis has never been given (in the literature), however when comparing the observed prevalence in the different studies we see almost the same in each age group. This indicates that a child who voids during sleep is an enuretic and that the severity of the problem varies from once a month to every night. The question as to when enuresis is to be considered pathological must be a matter of when the child or parents cross an iatrophropic limit."

Norgaard is suggesting that bed wetting becomes a problem when the parents and the child say it is, rather than at some arbitrary age and with some arbitrary frequency decided on by health care professionals. Norgaard's perspective is the one which came to be adopted in this study (Section 3.6.2).

This is not to say that it is inappropriate for researchers to decide on operational definitions of bed wetting which involve a specification of the age of the children to be included and the minimum frequency of bed wetting (wet nights per week or month). However, such criteria should be decided in relation to the purpose of the study. In a series of studies of the pathophysiology of bed wetting (Norgaard et al, 1985a,b, 1989a,b; Norgaard, 1989a,b), Norgaard himself only included children who usually wet the bed on three or more nights per week for the practical reason that the research involved intensive monitoring and was designed to give a good possibility of studying enuretic episodes. Butler (1991) has suggested a set of standard definitions to be used in research into the outcomes of trials of treatment efficacy. He has proposed that for such studies young people should have been shown to wet the bed on at least seven nights in a two week period prior to inclusion in any study.

Primary and secondary bed wetting

A distinction is often made in the literature between primary and secondary bed wetting but there is no universal agreement on the criteria to be used to differentiate between them. According to Forsythe and Redmond (1974, p.259):

"Primary nocturnal enuresis refers to the child who has never been dry at night and secondary or acquired nocturnal enuresis refers to the child who has been dry for at least a year before the onset of enuresis."

They do not specify a lower age limit. In another study Fergusson et al (1990, p.54) used the criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM3) which defines secondary bed wetting as:

"The onset of bedwetting after the age of 5 years following at least 1 year during which the child had remained dry at night."

Other researchers have reduced to 6 months the time for which the child has to have been dry before being classified as having a secondary problem (eg. Devlin, 1991; Hjälmås, 1992; Jarvelin et al, 1990, 1991).

Cross-cultural perspectives

To shed some light on the cultural aspects of bed wetting, it is perhaps helpful to comment briefly upon the few cross-cultural studies that have been reported, such as Abramovitch and Abramovitch, 1989; Bose, 1992; Butler and Golding, 1986; de Jonge, 1973; Karandikar, 1992. In these studies bed wetting has been defined in many different ways. The prevalence rates quoted vary considerably, but they all suggest that the age at which a child is expected to be dry at night is culturally determined and can vary considerably in different cultures. Evidence from a health visitor involved with this study suggests that in another culture in the Far East, where the climate is warmer and the practical consequences of bed wetting are much easier to manage, wetting the bed is not a cause of anxiety and tension between mother and child and the age of attainment of day and night time bladder control is not an issue. In this Far Eastern culture the achievement of many other developmental milestones such as the child's first tooth, first words and first attempts at walking are noted and talked about with as much interest as they are by parents in the UK.

In conclusion, both the social and the medical perspectives on bed wetting have merits in terms of what they highlight but each has deficiencies because of what is under-played or ignored. An understanding of both perspectives is important for nursing practice, as the community nurse is often the first port of call for concerned parents and many nurses have a responsibility for the assessment and support of the child and his or her family over quite prolonged periods in early childhood (Chapter 7).

2.2.2 The epidemiology of bed wetting

Epidemiology is the study of the distribution of a disease or a pathophysiological condition in human populations and the factors that influence this distribution (Lilienfeld, 1978). Bed wetting is often thought of as a condition of childhood, yet it can affect some people into adolescence and even into their adult life. This section reviews what is known about the prevalence of bed wetting, the frequency of its occurrence for individuals (expressed as affected nights per week or month) and the proportion of bed wetters who also have day time urinary problems.

What proportion of the population wet the bed?

The lack of a universally accepted definition of bed wetting and the lack of agreement on the criteria for differentiating between primary and secondary bed wetting (Section 2.2.1) makes a meaningful comparison of the numerous epidemiological studies very difficult (e.g. Blomfield and Douglas, 1956; Devlin, 1991; Dodge et al, 1970; Foxman et al, 1986; Hellstrom et al, 1990; Jarvelin et al, 1988; Oppel et al, 1968a; Rutter et al, 1973; Verhulst et al, 1985). In a survey of the literature as long ago as 1973, de Jonge found that prevalence rates quoted for children varied from 1-40% depending on the characteristics of the populations studied and how the researchers defined bed wetting.

However bed wetting is defined, it is generally accepted that it is a common problem which could be affecting as many as half a million children in the UK (Blackwell, 1995). Based on an average of two wet nights per week, it has been estimated that 15-20% of five year olds, 7% of seven year olds, 5% of ten year olds, 2 - 3% of 12 to 14 year olds and 1 - 2% of 15 year olds and over wet the bed. It

is however a condition which many people and their families chose to keep secret and many sufferers believe themselves to be alone.

Norgaard (1991) estimates that 10-15% of all bed wetters are secondary bed wetters. In a survey of 1806 school children aged 4 to 14 years in Ireland, Devlin (1991) found the percentage of secondary bed wetters to be somewhat higher at 30%. In a birth cohort study in New Zealand which followed 1265 children for the first ten years of life, Fergusson et al (1990) found that 7.9% of the children had developed a secondary bed wetting problem by the age of ten years.

Bed wetting is reportedly more common in boys than girls, at least among younger children, (de Jonge, 1973; Devlin, 1991; Foxman et al 1986; Hellstrom et al, 1990; Verhulst et al, 1985), which lends some credence to those who think that bed wetting is associated with delayed physical development (Jarvelin 1989).

In a longitudinal study of untreated bed wetters Forsythe and Redmond (1974) showed an annual "spontaneous cure rate" of 14% between the ages of five to nine years and a 16% "cure" rate between the ages of ten to nineteen years. As there is such controversy about whether bed wetting is a disease or not, it is more appropriate to say that every year the condition resolves for about one young person in six.

How frequently do individuals wet the bed?

As in many instances it is not known whether there has been one or more than one bed wetting episode in one night (because the individual often does not wake up immediately after voiding), it has become customary to use frequency of bed wetting, expressed as affected nights in a given time period (usually per week or month) as an indicator of the severity of the condition, rather than the number of episodes per night.

In their study of 1129 enuretic children, Forsythe and Redmond (1974) found that 79% wet the bed seven nights per week, 11% five to six nights per week and 10% two to four nights per week. The absence of young people wetting the bed one night or less per week in this study could be a reflection of the referral criteria for the clinic, although this was never stated. As the sample comprised only

bed wetters attending an enuretic clinic it might be supposed that these were in the main the most severely affected children, in terms of the number of wet nights per week. Three more recent large scale epidemiological surveys, conducted in Scandinavia and Ireland by Jarvelin et al (1991), Hellstrom et al (1990) and Devlin (1991), probably give a more realistic picture of the frequency of wet nights over a given period for children living in the community, who may or may not be known to health care professionals.

From a sample of 141 children, identified as bed wetters from a survey of 3375 seven year old children in a region in Finland, Jarvelin et al (1991) found that 35% wet the bed on more than 14 nights out of 30, 61% wet the bed 1 to 14 nights in 30, and 5% wet the bed less than once a month. In a survey of 3556 seven year old school entrants in Sweden, Hellstrom et al (1990) found a high percentage of occasional bed wetters with 64% wetting less than once a week but at least once in three months. Devlin's (1991) survey of the parents of 1806 school children aged 4 to 14 years in County Kildare, Ireland, is nearest in age range to the range of ages of the young people in this study, which was 4 to 17 years. Devlin found that 33% wet the bed between once a month and less than once a week, 11% wet the bed once a week, 25% wet two to four nights a week, and 31% wet the bed on five to seven nights a week.

What proportion of bed wetters also have day time urinary symptoms?

The prevalence of day wetting among bed wetters has been reported in several studies (e.g. Bloom et al, 1993; Blomfield and Douglas, 1956; Devlin, 1991; Fergusson et al, 1986; Hellstrom et al, 1990; Jarvelin et al, 1988 and Oppel et al, 1968a) and is estimated to be within the range of 10-20%. However a comparison between studies is again made difficult because of the different definitions of day wetting used.

Hellstrom et al (1990) defined nocturnal and diurnal incontinence as "wetting at least once every 3 months" (p.434) but did not define incontinence in terms of the volume of urine lost. Hjälmås (1992) claims that 1 ml of urine is enough to cause some social inconvenience but this volume may not always be noticeable to others. Meadow (1990) has developed a three grade system which distinguishes between the loss of small and larger volumes of urine in a way which may be relevant

for the young person in terms of the social consequences of incontinence and the ease or otherwise of keeping it a secret. His grading system is:

- "1. Damp pants and underclothes, but urine does not seep through to the outer clothing.
2. Wetting does seep through to the trousers or skirt, making a visible wet patch.
3. A wet puddle on the seat or floor."

Meadow (1990) p.179

In his experience complete voiding in the day time (a puddle on the seat or floor) is rare. Most of the children presenting at his clinic had a mixture of grade 1 and grade 2 incidents.

Data on other urinary symptoms such as urgency in children is much more scarce. In a study of 3556 seven year old school entrants in Sweden, Hellstrom et al (1990) found that most children had a moderate form of urgency. Urgency was defined in Hellstrom et al's (1990, p.434) study as:

"... a short latency period between first sensation and a need to void which occurred daily and was not caused by a voluntary delay."

5% of the total sample were classified as having imperative urgency requiring full concentration on holding, such as assuming a squatting position.

2.2.3 Approaches to the management of bed wetting

This section gives an overview of approaches to the management of bed wetting from a historical perspective, from the perspective of health care professionals and from the perspective of lay people who may or may not have direct experience of caring for a bed wetting child. The purpose of this brief review is not to debate the relative merits of different treatments but to demonstrate their diversity, which may be a reflection of the lack of consensus among health care professionals on the nature of bed wetting and its aetiology (Section 2.2.1).

A review of treatments used in the 19th Century identified methods such as creating blisters on the sacrum, requiring a child to sleep in a frame which elevated the pelvic floor, or making young people eat porridge boiled in their own urine (Borstelmann, 1983; Buchan, 1994; Glicklich, 1951; Salmon,

1975). These would today be regarded by many as little short of child abuse, yet each method had a rational if ill-informed basis.

The diversity of therapeutic approaches in common use today suggests that there is still some way to go in understanding the causes of bed wetting and the ways in which various genetic and environmental factors could be interacting. Methods in common use include:

- various forms of behavioural training (e.g. Azrin et al, 1974; Azrin & Thienes, 1978; Bollard and Nettlebeck, 1982; Butler et al, 1988, 1990; Fielding, 1980; Fordham & Meadow, 1989; Forsythe & Butler, 1989; Gustafson, 1993; Kaplan et al, 1989; Morgan, 1978; Papworth, 1989; Scott et al, 1992; van Londen et al, 1993; van Son et al, 1990; Whelan & Houts, 1990)
- pharmacologically reducing the rate and volume of urine production overnight (e.g. Hjälmås & Bengtsson, 1993; Miller et al, 1992; Rittig et al, 1989)
- pharmacologically increasing bladder capacity by diminishing detrusor contractions
- relaxation and mental imagery (e.g. Kohen, 1991)
- self hypnosis (e.g. Olness, 1975)
- visualisation (e.g. Butler, 1993a)
- hypnotherapy (e.g. Edwards & van de Spuy, 1985; Simpson, (1991), and
- acupuncture (e.g. Minni et al, 1990; Xu, 1991).

Underpinning each method is a different perspective on the causes of bed wetting.

As bed wetting is mostly managed by the family in the home setting, and there is some evidence that many families rarely if ever seek professional help (Devlin, 1991; Foxman et al, 1986; Haque et al, 1981) it is important to consider what parents do of their own volition to stop the bed wetting.

There is much agreement about the methods commonly used by parents as described by Bollard & Nettelbeck (1989), Butler (1987, 1994), Butler & Brewin (1986), Haque et al (1981), Morgan (1981, 1988), Shelov et al (1981) and Woolnough (1992). Many parents stop their child from taking a drink an hour or two before the young person's bed time, and lift the child at their own bed time. Many parents attribute their child's bed wetting to deep sleep and some try using an alarm clock to

wake the child at a set time in the night. It is commonly reported that parents offer rewards for dry nights. Butler (1993a) and others have noted that some parents punish their children for bed wetting.

In a survey of consecutive referrals to a clinical psychologist in the UK for treatment of bed wetting, Butler et al (1993) found that only 6 (4.5%) of the 134 mothers who completed the 20 question Maternal Tolerance Scale (Morgan and Young, 1975) answered Yes to the question: "I punish him/her for bed wetting". This is in contrast to the findings of Haque et al (1981) who found that 35.8% of a total of 346 parents attending one of nine paediatric hospital departments in the United States reported on a 20 question questionnaire that they punished the child for wet nights. It is not possible to say whether the mothers in Butler et al's (1993) study under-reported the use of punishment or whether the parents define "punishment" differently in the UK and the USA, or whether there is a genuine cross-cultural difference in parents' tendency to use punishment between the UK and the USA. A comment by a health visitor tutor, quoted by Leenders (1993, p.93) suggests that it may be difficult for some parents to admit to the use of punishment:

"Corporal punishment seems no answer yet parents have 'confessed' that the bed wetting stopped after years of sympathetic understanding when the mother lost her temper and lashed out."

Through this literature review, which was undertaken prior to the researcher's first contact with families, an understanding was gained of the wide variety of approaches to the management of bed wetting advocated by health care professionals and the methods most commonly used by the parents of a bed wetting child. This sensitised the researcher to the topic (Section 3.9.1) and also helped to facilitate a more accurate and immediate understanding between the researcher and the family members when various treatment methods were discussed.

2.2.4 The impact of bed wetting on the individual and the family

This section begins with an overview of the literature on the psychological and social consequences of urinary incontinence of whatever cause for people of all ages, before summarising what is known of the impact of bed wetting on the individual and the family.

The psychological and social consequences of urinary incontinence

Urinary incontinence has been defined by the International Continence Society Committee on Standardisation of Terminology as:

"...involuntary loss of urine which is objectively demonstrable and a social or hygienic problem."

Abrams et al (1988) p.17

This definition suggests that there should be an objective assessment of the loss of urine but it also implies that incontinence is in part culturally defined and is influenced by cultural values, social norms and culturally shared rules of interpreting the event as "a social or hygienic problem".

A review of the literature from western Europe and the USA on the psychological and social effects of urinary incontinence in all age groups, whatever the cause, suggests that the involuntary loss of urine can have far reaching consequences for the individual including effects: on self-perception (Lagro-Janssen et al, 1990; Dowd, 1991; Mackaulay et al, 1991); interpersonal relationships (Parker, 1993); sexual activity (Sutherst, 1979; Norton et al, 1988) and quality of life (Herzog et al, 1988; Yu et al, 1989). Studies show that the individual's perception and interpretation of the symptoms of urinary incontinence help to determine the person's response to these symptoms, including whether or not they seek help from health care professionals (Herzog et al, 1989; Burgio et al, 1991; Rekers et al, 1992) or modify daily routines, work, leisure and social activities (Norton, 1982; Wyman et al, 1987, 1990; Hunskaar and Vinsnes, 1991).

The psychological and social consequences of bed wetting for the individual and the family

"I still have some wet nights now; usually when I get upset because I'm very lonely. I can't make friends in case they ask me to their homes, and then stay the night. I have never been away for a holiday in my life because of complaint and dare not go to cinema or any crowded place as I must dash to toilet more often than most people. So now I'm shut away in my own house, not seeing no one or having anyone to talk to and cannot make friends or join any clubs or anything. It'll hang over me to my dying day - an outcast in a modern world, always longing for a woman friend and a nice holiday."

Extract from a letter written by a 61 year old bed wetter,
cited in Stone (1973) p.1

As this quotation illustrates, bed wetting can affect some individuals into old age with devastating effects on many aspects of their lives, including the development of close personal relationships, in

ways which are reminiscent of the reported effects of urinary incontinence more generally, described at the beginning of this section.

Anecdotal reports from health care professionals with a special interest in continence, such as continence nurse advisers and clinical psychologists running enuresis clinics, suggest that bed wetting can be distressing for the sufferer, of whatever age, leading to feelings of embarrassment, anxiety, loss of self esteem and occasionally physical abuse from other members of the family (Barry, 1988; Butler, 1987; Dobson, 1989; Moreton, 1989; Norton, 1986, Reinhard, 1989 and Shapiro, 1989). Sufferers are widely reported to be reluctant to stay overnight with friends, and young people are reportedly reluctant to take part in school trips which involve staying away from home (Butler, 1994). It has been suggested that bed wetting can make young people reluctant to leave home but bed wetting which persists into adulthood has also been implicated as a factor contributing to homelessness (Stone, 1973).

In her guide to enuresis for professionals, Blackwell (1989) paints a bleak picture, suggesting that persistent bed wetting may lead to: parents feeling anxious, guilty and eventually experiencing loss of confidence in their parenting skills; difficulties in the relationships between parents and children, and the child losing confidence, possibly becoming withdrawn, having difficulty making or keeping friends and under-achieving at school. Gibson (1989, p.270) describes bed wetting as "a family's recurrent nightmare" which she says can have devastating consequences for the family and the child's self image.

When reading these accounts the researcher was reminded of her encounter with the mother of a bed wetting adolescent which triggered the researcher's interest in the topic of bed wetting and led to this study (Section 1.2). The mother described living with a bed wetting 16 year old as "hell".

After reviewing the largely anecdotal literature on the impact of bed wetting on the individual and the family the researcher was left with three inter-related questions:

- 1) Are the negative and pervasive consequences of bed wetting, as reported in the literature and by the mother who triggered this study, the reality for all young people who wet the bed and their families or are they one extreme but important end of a continuum of experience?
- 2) Are there any bed wetters leading lives which they regard as being unaffected or only minimally affected by bed wetting?
- 3) Are all young people and their parents equally concerned about bed wetting?

Some light is shed on these questions by the findings of two studies.

In a study of 127 consecutive referrals to a community based enuresis clinic whose main purpose was to explore, through structured interviews, factors predicting the outcome of treatment with an enuresis alarm, Devlin and O'Cathain (1990) found that 42% of parents and 32% of young people were concerned "a great deal" about bed wetting, 44% of parents and 34% of young people rated their concern as "moderate" and 14% of parents and 34% of young people as "a little" or "none". This study suggests that there may be differing perceptions among young people and their parents about the impact of bed wetting on their lives but it does not answer the questions: "Who is most concerned, and why?"

In a collaborative study of parental perceptions of bed wetting involving paediatricians from nine medical centres in the United States, Haque et al (1981) found that 20% of the 331 parents who completed a 20 question questionnaire were "very worried" about their child's bed wetting, 65% were "concerned but not alarmed" and 14% were "sometimes worried". These researchers found that parents with the least formal education were most worried about their child's bed wetting and most likely to consult a physician about it. They found that 70.6% of the least educated, "Grade School", parents punished their children for bed wetting compared to 34.5% of High School educated parents and 31.8% of College educated parents. The Grade School parents were also found to be the most concerned about changing the wet sheets and about the smell of the wet bed. It could, however, be that the Grade School educated parents reported their feelings and practices more truthfully than the High School educated parents. There is no way of knowing from Haque's study what these parents actually did within the home, and why. The studies by Devlin and O'Cathain (1990) and Haque et al (1981) do, however, suggest that not all parents and young people are equally concerned about the bed wetting.

2.3 The family

2.3.0 Introduction

In this section the literature on the nature of the family and the dynamics of the interaction of family members is briefly reviewed. A number of important methodological issues are raised in relation to family research.

2.3.1 Definitions of a "family"

"Everyone knows what a family is, yet no one seems to be able to find a definition that is acceptable to everyone. Should the definition include only those people related by blood, marriage or adoption, living under one roof ... or should a definition also include a daughter away at college, the mother's current live-in lover, the non-custodial husband and his wife, with whom the children spend every other weekend, the grandparent who lives next door but spends most of every day tending the children while the mother works ...?"

Broderick (1993) p.51-52

There is no universally accepted definition of what constitutes a family (Yerby et al, 1995). Social scientists often make the distinction between the nuclear family, typically identified as a parent or parents and a child or children, and the extended family, which typically includes grandparents and other relatives. It is difficult and ultimately arbitrary to decide what is meant by a family. Definitions of the family are not widely agreed upon by families themselves (Jorgenson, 1989). Who is considered to be "family" is, in part, culturally determined. Doherty (1986) describes the family as an abstraction. Certainly there is a variety of possible definitions.

The operational definition of a family adopted at the start of this study was that it should include the young person who wet the bed and the parent or parents with whom he or she was living. This definition is compatible with the definition of a family commonly used for census purposes, which is:

"Two or more persons, sharing a common residence and related by blood, adoption or marriage"

Broderick (1993) p.52

However, according to this definition a family could be two sisters living together or a married couple without children. The following more recently published definition of a family is more congruent with this study's findings, encompassing as it does key concepts which facilitate an understanding of family process:

"A family is a multigenerational social system consisting of at least two interdependent people bound together by a common living space (at one time or another) and a common history, and who share some degree of emotional attachment to or involvement with one another."

Yerby et al (1995) p.13

Describing a family as "multigenerational" emphasises the importance of relationships between parents and children and the influence of inter-generational influences on the family as a whole (Minuchin 1985, 1988; Simmons et al, 1993). It is the inter-gender and inter-generational nature of relationships within the family which make it unique as a social system. Unlike all other organisations families incorporate new members only by birth, adoption or marriage and members can leave only by death.

With the exception of the parent-parent dyad, relationships within families are non-voluntary. Any reorganisation of the family is generally within the control of the parents who may decide to separate, divorce and remarry irrespective of the wishes of their children. Until they are old enough to leave home young people are enmeshed as dependants in a network of relationships which may be supportive and a potent source of personal growth or which may be damaging. At the worst this unequal relationship between parents and children can lead to child abuse (Briere, 1992; Dalos and McLaughlin, 1994; Findlay and Salter, 1992; Mennen and Meadow, 1994; and Stainton-Rogers et al, 1989).

A family exerts an influence over its members which can endure for a lifetime and extend beyond one generation. It is in the family context that children first learn how valued, loved and loveable they are. Although a child's self-concept (the composite of positive and negative feelings about self) continues to grow and change throughout life, there is a growing body of evidence that many of a person's most enduring feelings about themselves are developed at an early age and are reinforced or

modified by information received from other family members (e.g. Amato, 1986a,b; Belsky, 1981, 1990; Caspi and Elder, 1988; Clarke-Stewart, 1988; Cummings et al, 1989; Donley, 1993; Dunn and Brown, 1994; Eisenberg and Fabes, 1994; Gecas and Schwalbe, 1986; Hinde and Stephenson-Hinde, 1988; Lamborn et al, 1991; Noller, 1994).

Yerby et al's (1995) definition of the family given above acknowledges the family's "shared history", as well as the influence of the experiences which each parent brings to a family from their family of origin. Shared history refers to the shared experiences, meanings and values associated with a family unit as it functions and evolves over time.

In Yerby et al's (1995) definition of the family, "attachment" and "involvement" refer to the intimate social bonds that link family members, which may not be visible to wider family, neighbours or researchers. "Inter-dependence" means that each family member's behaviour influences and is influenced by every other family member's behaviour. An acknowledgement of this characteristic of the family is pivotal to family systems theory, which is described below.

2.3.2 The family as a social system

"Study of the family in our day must include a consideration of systems theory."

Whyte (1994) p.32

The term "system" describes an integrated whole in which the parts or members are interconnected with one another in a complex web of relationships. A body of knowledge which is often referred to as family systems theory has come to form the conceptual foundation of a great deal of therapy, research and policy making in the family field (Rosenblatt, 1994).

The published works on family systems theory are so diverse (e.g. Belsky, 1981; Bronfenbrenner, 1986; Hinde, 1989; Olson, 1989; Minuchin, 1988; Patterson and Dishion, 1988) that it is misleading to write as though there is a single theory. However, the field is not chaotic. There are simply a number of perspectives such as the interpersonal perspective of Hinde or the ecological perspective

of Bronfenbrenner which each focus on a different aspect of the family system and its place in the wider world.

The purpose of this overview of families as systems is to highlight common elements of these different perspectives which have helped to sensitise the researcher to the dynamics of what was going on, when analysing the data from this study. This review is also reflective, raising some fundamental methodological issues, including the extent to which a researcher can capture the reality of a situation from the family's perspective, when this reality is in a constant state of change.

In this study, family systems theory has come to be regarded as a tool for helping the researcher to see what might otherwise be missed, in the way that Rosenblatt describes:

"Thinking in terms of family systems can provide striking new realities and perspectives on what had been taken as reality; it is like being able to use microscopes and telescopes when previously one could only see things with the naked eye".

Rosenblatt (1994) p.33

Family systems theory is merely a metaphor, and like all metaphors it has both strengths and limitations. These are commented upon in Chapters 5 and 6 in relation to the extent to which the principles of family systems theory were seen to apply to the concepts which emerged during this study.

Four characteristics of the family as a system are briefly commented upon below, namely: wholeness; the inter-dependence of family members; the presence of subsystems within systems, and the dialectic between homeostasis and change.

The wholeness of the family

Wholeness implies that no one element of a system can be understood in isolation from other system elements. Inherent in this concept is also the idea that the whole is more than the sum of its parts. This has important implications for any study involving the family. This stance was instinctively adopted by the researcher during the earliest phase of this study's design.

The interdependence of family members

The central tenet of family systems theory is the principle of interdependent components mutually and simultaneously influencing all other system components (Broderick, 1993). The characteristic of inter-dependence is completely congruent with one of the central axioms of the naturalist paradigm, chosen to guide the selection of methods in this study, and described by Lincoln and Guba (1985) as "mutual simultaneous shaping". Yerby et al (1990, p.10) describe the general consequences of the characteristic of inter-dependence of family members:

"Inter-dependence implies that no family member is totally in control, inaccessible, or unmoved by the actions of other family members. Although one or more individuals may be accorded more power in the family unit, all individuals are affected by the actions of others."

In the second edition of their book *Understanding Family Communication* Yerby et al (1995) liken the connections between members of a family to rubber bands. Activity by one member tugs on the other members. The effect may be temporary but if the altered tension between individuals is maintained this can lead to a realignment of all family members until a new equilibrium is reached.

The concept of inter-dependence fundamentally challenges the positivist notion of linear causality (Yerby et al, 1995). Acknowledging the interdependence of family members and the principle that family members influence one another in complex and dynamic ways, encourages the researcher to move beyond the uni-directional and bi-directional approaches to understanding the interaction between parents and children which characterised most family research before 1980 (Stafford and Bayer, 1993).

The presence of subsystems within the family

Minuchin (1985) describes how each family with children is composed of subsystems such as the parent-parent subsystem, and subsystems between each parent and each child and amongst siblings. In a family with two parents (P1 and P2) and two children (C1 and C2) there is the possibility of ten subsystems. While it was customary for family researchers to think in dyads such as parent-parent (P1+P2) or parent-child (eg. P1+C1), it is now acknowledged that a subsystem can develop between three members of the family which excludes the fourth, eg. P1+C1+C2 - where perhaps a step father

is excluded, or P1+P2+C1, where C2 is a scapegoated child. The alliances developed between family members can have an important influence on the functioning of the family as a whole.

The response of families to change

The dialectic between homeostasis and change is currently the subject of some debate between family systems theorists and is worthy of note when considering the findings of a study such as this where the emphasis is on uncovering processes and repeated patterns of behaviour. Stafford and Bayer (1993, p.31) describe the two opposing processes:

"Families resist change and strive to maintain the status quo; system members cling to current patterns of interaction. Changes are stressful, whether they are normal life-course changes or unexpected events. None-the-less, families do change. Families transform in response to each member's development as well as to the development of the constituent dyads (e.g. marital, sibling, and so forth). In addition, events that occur with the passage of time, such as the birth of a new member, an accident in the family, and so forth, modify family interaction patterns."

It is now being suggested that a family's desire to resist change has been over-stated by the earlier family systems theorists. The management of change is coming to be seen as a primary function of the family and maintenance of stability as a secondary function. Chang and Phillips (1993) have gone so far as to suggest that change is continuous and stability is an illusion.

Some phenomenologically oriented interpretivist researchers suggest that social processes are ephemeral, fluid phenomena with no existence independent of the social actors' ways of construing and describing them, so that the search for repeated patterns in behaviour is futile (Miles and Huberman, 1994). As a result of undertaking this study this researcher has come to believe that patterns in parents' and young peoples' behaviour are discernible (as described in Chapters 5 and 6) but has also come to recognise the dynamic nature of reality for the family. While it is useful to be able to identify patterns in a family's interactions it is acknowledged that families are in a constant state of flux. The ability to identify stable roles and patterns of behaviour may help an understanding of a family at a point in time but as Rosenblatt (1994) points out, time and motion, like a river, keep the family in a continuous state of change.

The absence of the concept of families as systems in the literature on the management of bed wetting

While undertaking this review of the family literature in response to questions raised by the data emerging from the study, the concept of families as systems was found to be a widely accepted foundation for recent family research and to be the foundation of many therapeutic approaches to diverse family problems (Burr and Klein, 1994; Dallos, 1995; Gelles, 1995; Muncie et al, 1995; Wegner and Alexander, 1993). However, no discussion of the family as a system was encountered during the initial literature review on bed wetting (Section 2.2) suggesting that bed wetting has not been researched from this perspective.

This may be because the little research that there has been on family processes in relation to the management of bed wetting in children has been conducted by clinical psychologists. Psychologists have tended to lag behind sociologists in seeing the implications of family systems theory because, until relatively recently, the focus of psychological research has been the individual rather than the individual as part of a family group (Stafford and Bayer, 1993).

The only systematic research that there has been on family process is research led by a clinical psychologist, who has studied the consequences of "maternal intolerance" for the outcome of behavioural treatments such as the body worn alarm (Butler et al 1986, 1990, 1993), using a questionnaire originally developed by Morgan and Young (1975). This questionnaire includes such questions as:

"I worry more about my child's happiness than about a few extra sheets/clothes to wash ...
YES/NO"

cited in Blackwell (1989) p.49

Questions such as this contain an in built bias towards one response. Since appearing in a guide to bed wetting for professionals, published by the Enuresis Resource and Information Centre (Blackwell, 1989) the questionnaire has been modified (Butler, 1993b; Blackwell, 1995), but there is still a centrally important and unanswered question about what it is that this questionnaire is actually measuring.

In Butler's research the mother-young person dyad is the focus of interest and the research seems to be based on the premise that one aspect of a parent's personality (the attribute of "maternal

intolerance") can predict the outcome of treatment for the child. This approach is sometimes referred to as the social mould perspective (Peterson and Rollins, 1987) whereby children are assumed to be passive and to be moulded by the actions of their parents as though they were lumps of clay. This linear, uni-directional view of the nature of parent-child interactions has long been superseded in the family literature (Stafford and Bayer, 1993).

The concept of "maternal intolerance", as described by Butler, does not fully explain the wide variation in parental attitudes towards bed wetting, or their antecedents or consequences, as is made clear in chapter 6.

2.4 Summary

The literature review revealed that the aetiology of bed wetting is far from clear for the majority of bed wetters and is almost certainly multi-factorial. It revealed the divergence of views among health care professionals as to whether bed wetting should be categorised as pathological or not (Section 2.2.1), as well as differing perspectives on how to treat it (Section 2.2.3). Questions relating to the interplay between nature and nurture in this context have barely been addressed or even articulated, with many pathophysiologists dismissing the possible contribution of psychological factors to lack of night time bladder control.

A plethora of randomised controlled clinical trials of the efficacy of many different treatments was discovered. The literature also contains a number of anecdotal accounts and case histories illustrating the psychosocial consequences of bed wetting for the individual and the family. However, the review revealed a paucity of information on the ways in which bed wetting is managed within the context of everyday family life. In particular very little has been reported in the literature on the beliefs, feelings and roles of fathers and siblings.

The review confirmed that there were many unanswered questions about bed wetting and its management, within the context of every day family life. It also confirmed that the phenomenon had not been widely studied from the family's perspective. The implications of these findings for the study's design are described in the next chapter.

3.0 Introduction

This chapter is about the decisions involved in designing this study and its conduct in practice.

Kvale (1995) argues that the quality of the knowledge produced by an investigation rests on the quality of the craftsmanship with which every stage of the research process is conducted, including: the soundness of the theoretical pre-suppositions of the study; the appropriateness of the research design and methods for the study's topic and purpose, and the rigour of the verification process. Evaluation of the craftsmanship of a study by others requires that the research procedures used be explicitly stated and transparent.

The stages involved in this study's design and conduct are summarised in the form of a flow diagram (Figure 1). For the most part the structure of this chapter tells the story of this study's progress as it happened, beginning with the delineation of the initial research questions (Section 3.1), an explanation of the decisions involved in the selection of the research approach (Section 3.2) and an overview of the procedural implications arising from adopting it (Section 3.3). The confirmation of the appropriateness of the approach, in consultation with health care professionals locally, is described in Section 3.4. Much attention was paid during this time to a discussion of the ethical issues involved (Section 3.5).

The next four sections are concerned with describing and justifying the processes involved in data collection and analysis. Section 3.6 describes the processes of selective and theoretical sampling. Section 3.7 describes the methods of data collection used and the nature and duration of the involvement of individual families. Issues relating to the practicalities of data storage and data handling are described in Section 3.8. The specific procedures used in data analysis are described in Section 3.9, with the aid of a number of illustrations taken from many stages of the analysis process. Section 3.10 outlines some criteria for evaluating a study such as this.

FIGURE 1 The stages in the study's design and conduct

A. STUDY DEVELOPMENT AND DESIGN

(October 1992 - April 1993)

1. Literature review on the psychological and social consequences of urinary incontinence of whatever cause, in people of all ages (Section 2.2.4)
2. Identification of bed wetting as the research topic (Section 1.2)
3. Further literature review, specific to bed wetting (Sections 2.1 and 2.2)
4. Delineation of the broad research questions and selection of the overall research approach (Sections 3.1 and 3.2)
5. Selection of methods (Sections 3.3 - 3.9)
6. Development of draft research proposal for discussion.



B. CONSULTATION PHASE

(April - July 1993)

7. Consultation with health care professionals locally, including: the Chief Nurse and the Senior Nurse Research at the Health Board, the Director of Nursing Services and Quality for the community, health visitors, members of the GP Research Group and a senior consultant urologist (Section 3.4), about ethical issues (Section 3.5), mechanisms for sample selection (Section 3.6) and the study's overall design (Sections 3.3 and 3.7)
8. Submission of proposal to Ethics of Research Committee (June 1993)
9. Proposal accepted by Ethics of Research Committee (July 1993)



C. DATA COLLECTION AND ONGOING ANALYSIS

(August 1993 - June 1994)

10. Enrolment of families via health visitors (Sections 3.5 and 3.6, Table 2 and Appendix VII)
The procedure for each family, on return of consent form, is summarised in Section 3.7 and Figure 2.
11. Trial of computer software: NUD•IST Version 2.3 (Section 3.8) (December 1993).
12. NUD•IST Power Version 3.0 received from Australia. Construction of hierarchical coding index commenced (Sections 3.8 and 3.9) (March 1994)



D. CONTINUING DATA ANALYSIS AND WRITING UP OF THESIS

(July 1994 - August 1995)

13. Further development of coding index and data analysis facilitated by NUD•IST (Section 3.9)
14. Final "closure" on theory, facilitated by axial coding and the development of a conditional matrix (Section 3.9 and Chapters 6 and 7) (April 1995)
15. Write-up of thesis completed (August 1995)



E. DEBRIEFING OF PARTICIPANTS AND DISSEMINATION OF RESEARCH FINDINGS

(from October 1995 onwards)

16. Meeting with health visitors and GPs involved with the study (Section 3.10)
Letter and summary report to families
Writing of journal articles and dissemination of findings through appropriate interest groups e.g. ERIC

3.1 The research questions and the approach taken

"...a researcher's reading on a subject may suggest that a new approach is needed to solve an old problem ... Something about the problem area and the phenomena associated with it remains elusive, and that something, if discovered, might be used to reconstruct understanding of this phenomenon."

Strauss & Corbin (1990) p.35

The purpose of this study, as initially envisaged, was to explore the experience and meaning of bed wetting for young people aged 5 to 20 years and their families. A review of the literature confirmed that there was a great deal still to learn about how parents manage bed wetting in the context of every day family life and its impact on everyone in the family (Sections 2.2 and 2.4).

Prior to the first contacts with families the following broad research questions were framed:

1. How do parents and young people manage the practical consequences of bed wetting from day to day?
2. What impact do young people and their parents perceive bed wetting to have on the quality of their lives as individuals and on the quality of family life?

To seek answers to these questions it was decided that it would be most appropriate to use a qualitative research approach, an inductive process of inquiry and grounded theory methods of data analysis. The paradigm guiding the methods selected is the naturalist paradigm (Lincoln and Guba, 1985). The justification for the approach taken is given in Section 3.2.

Underlying the approach taken was the assumption that there could be concepts pertaining to the phenomenon of bed wetting that had yet to be discovered, or at least articulated in a coherent way, and the feeling that the relationships between concepts reported in the literature, such as "maternal tolerance" for the outcome of behaviourally oriented treatment, were poorly understood and underdeveloped (Section 2.4).

Data analysis began from the first contact with the first family. The following, more specific, research questions emerged during this early phase of data collection and data analysis:

1. How do young people feel about wetting the bed?
2. How do parents feel about the young person's bed wetting?
3. How do families manage the day to day consequences of bed wetting?
4. What part do the different family members play in the day to day management of the young person's bed wetting?
5. What are the social consequences of bed wetting from the young person's perspective and the parents' perspective?
6. When is a young person's bed wetting identified by the family as a problem requiring action?
7. What do parents do of their own volition to encourage the young person's bed wetting to stop?
8. What are the families' experiences of the methods suggested and the help received from health care professionals?
9. What are parents' and young people's beliefs about the causes of bed wetting?
10. Where do parents' and young people's beliefs about bed wetting come from?
11. Is there a relationship between parents' beliefs about bed wetting and their behaviour towards their bed wetting child?
12. Does the young person's behaviour have any influence on the parents' behaviour in relation to the management of bed wetting?

These questions were culled from the earliest organisations of the themes emerging during the open coding of the conversation transcripts. The first nine questions became major branch headings in the hierarchical coding tree developed to facilitate more rapid access to the data (Section 3.9.3).

The questions are for the most part a refinement of the broader questions initially framed, yet they rapidly took the emphasis of the study beyond a descriptive understanding of the meaning of the experience of bed wetting, from the perspective of individual family members, towards a new understanding of the processes going on within families and the conceptualisation of the family as a

unique, multi-generational social system. Many more questions came to be asked of the data during analysis (Section 3.9), in particular, questions about the relationship between emerging concepts (Chapter 6).

The reasons for adopting the naturalist paradigm and grounded theory generating methods for this study are described below.

3.2 A justification of the approach taken

Reasons for adopting the naturalist paradigm

"Paradigms represent a distillation of what we think about the world (but cannot prove). Our actions in the world, including actions that we take as inquirers, cannot occur without reference to those paradigms: 'As we think, so do we act'."

Lincoln and Guba (1985) p.15

A paradigm provides a way of looking at the world and a way of handling its complexity. It is a set of metaphysical beliefs. A paradigm influences a field of study by providing the assumptions and the "rules" by which a study is carried out and the criteria by which a study is judged (Erlandson et al, 1993, p.7).

Influenced initially by reading Denzin (1978), Gilgun et al (1992), Leininger (1985a), Miles and Huberman (1984), Morse (1991a, 1992b), Silverman (1985), Van Maanen (1983a), and Lincoln and Guba (1985) in particular, the positivist paradigm was rejected in favour of the naturalist paradigm, for the purposes of this study. The reasons for this decision are related to the assumptions implicit in each paradigm.

The assumption of the positivist paradigm that there is a single, tangible, quantifiable, fragmentable reality (Table 1) justifies the reductionist approach to studying phenomena. The assumption of the positivist paradigm that the researcher is independent from the object of research requires strenuous efforts to ensure objectivity. The concept of linear causality, so central to the positivist paradigm, determines the ultimate purpose of the research based upon it, namely the search for law-like principles to explain phenomena, which are time, context and value-free.

TABLE 1 A comparison of some of the assumptions of the positivist and the naturalist paradigms (based on Lincoln and Guba, 1985)

| Assumptions about | Positivist paradigm | Naturalist paradigm |
|--|--|---|
| 1. The nature of reality (an ontological assumption) | <p>Reality is single, tangible and fragmentable</p> <p>There is a reality which can be broken down into independent variables and processes, any of which can be studied independently of the others; inquiry can converge on to that reality until finally it can be predicted and controlled. The whole is the sum of the parts</p> | <p>Realities are multiple, constructed and holistic</p> <p>Multiple, constructed realities can only be studied holistically; inquiry may raise more questions than it answers so that prediction and control are not inevitable outcomes although it is reasonable to anticipate that a new level of understanding of a phenomenon can be achieved</p> |
| 2. The relationship of the knower and the known (an epistemological assumption) | <p>The knower and the known are independent</p> <p>The assumption is that the observer can be separated from the observed</p> | <p>The knower and the known are interactive and inseparable</p> <p>The assumption is that the inquirer and the subject of inquiry interact and influence one another in a way which is inescapable</p> |
| 3. The possibility of generalisation | <p>Time and context-free generalisations are possible</p> | <p>Only time and context bound tentative theories are possible</p> |
| 4. The possibility of causal linkages | <p>There are real causes, temporally precedent to their effects</p> <p>This is the assumption of linear causality</p> | <p>All entities are in a state of mutual simultaneous shaping so it is impossible to distinguish causes from effects</p> <p>It may however be possible to distinguish repeated patterns in interactions</p> |
| 5. The role of values (an axiological assumption) | <p>Inquiry is value free</p> <p>An assumption that the methodology guarantees (or aims to guarantee) that the results of an inquiry are essentially free from the influence of inquirer values</p> | <p>Inquiry is value bound</p> <p>This assumption acknowledges that the inquirer's values will influence the choice of topic, approach and method and that values may be inherent in the context of inquiry</p> |

Positivism has at least two consequences that run contrary to the naturalist paradigm namely: determinism - with its implications for human free will, and reductionism - which would make all phenomena, including human phenomena, ultimately subject to a single set of laws.

By contrast, in the naturalist paradigm the nature of reality is seen as multiple and constructed (Table 1). It follows from this that multiple, constructed realities can only be studied holistically. In the naturalist paradigm the researcher and the researched are recognised as being inter-active and inseparable. Findings are seen as time and context bound. This limits transferability of the findings to other times and other settings.

A central axiom of the naturalist paradigm, which makes it so appropriate for the study of families as social systems (Stafford and Bayer, 1993), is the axiom of "mutual simultaneous shaping" which is the principle of interdependent components mutually and simultaneously influencing all other components (Section 2.3.2). If the assumption of the interdependence of family members is accepted it becomes illogical to look for linear causality. Interactions within the family are seen as a spiral of recursive feedback loops (Minuchin, 1985). The aim becomes the search for sequenced patterns of interactions and mutual influence which define relationships.

Reasons for choosing grounded theory methods of data analysis

"A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge."

Strauss and Corbin (1990) p.23

A grounded theory is a theory grounded in data, which has been arrived at inductively rather than deductively. It could be argued that all naturalistic inquiry using qualitative methods which results in a theory which is grounded in the data has led to the development of a "grounded" theory. However, adopting a grounded theory approach from the outset of a study defines the generation of a theory as the primary purpose of the inquiry. The theory does not emerge as a serendipitous outcome but

through the systematic use of a set of analytic procedures, as originally articulated by Glaser and Strauss (1967).

The grounded theory approach requires the researcher to approach data collection without a preconceived theoretical framework (Morse, 1992a). A theory is developed inductively about a phenomenon from data which have been obtained from the real life setting. The relationships between the concepts which emerge from the data are tested in a constant comparative way and integrated with the help of coding paradigms such as axial coding (Strauss and Corbin, 1990) (Section 3.9.4).

Grounded theory methods have been used in many studies of a wide variety of phenomena over the last three decades, including: the control of information given to the dying patient (Glaser and Strauss, 1965, 1968); how couples work together to manage chronic illness in the home (Corbin and Strauss, 1984); work and the division of labour (Strauss, 1985); how patients become "ordinary" on leaving psychiatric hospital (Lorencz, 1988); the informed consent process (Nusbaum and Chenitz, 1990); the negotiation of commitment and involvement in the nurse-patient relationship (Morse, 1991b); how individuals learn diabetes self-management (Price, 1993); and how older women experience and manage urinary incontinence (Dowd, 1991). The approach has shown itself to be of value in developing a new understanding of many practice-related topics and has contributed to nursing knowledge and to nursing theories relating to health and health care (Field and Morse, 1985; Chapman, 1989).

A number of other qualitative research approaches including: ethnography (Aamodt, 1982, 1991; Agar, 1986; Hammersley and Atkinson, 1983 and Leininger, 1985c); ethnomethodology (Livingstone, 1987); ethnoscience (Morse, 1991c); Heideggerian hermeneutics (Gullickson, 1993; Wilson and Hutchinson, 1991), and phenomenology (Anderson, 1991; Kelpin, 1984; Smith, 1989) were considered. However, it was decided that the grounded theory approach would be the most appropriate when seeking answers to the broad questions framed at the start of this study as there seemed to be so many unanswered questions relating to the dynamics of families' experiences of bed wetting and its management (Section 2.4). As the literature review revealed that the topic had not

been previously researched from a family perspective, grounded theory generating methods seemed particularly appropriate with their emphasis on uncovering process. The intention was to move beyond an understanding of what is happening to why and how. The approach has proved itself to have been particularly appropriate for this study in practice, as is demonstrated in Chapters 5-7.

3.3 Procedural implications of adopting the naturalist paradigm and a grounded theory approach

The essence of qualitative methods is induction, that is the development of theory from data. An emergent research design is axiomatic:

"N (the naturalist) elects to allow the research design to emerge (flow, cascade, unfold) rather than to construct it preordinately (*a priori*) because it is inconceivable that enough could be known ahead of time about the multiple realities to devise the design adequately."

Lincoln and Guba (1985) p.41

This means starting without preconceived conceptual frameworks (Morse, 1992a), making observations, identifying key concepts and patterns in the data and testing the relationships between concepts using a variety of techniques. The process is recursive. There is a purposeful grounding of the verification process in the actual data but ultimately the researcher moves beyond the data to a new understanding of the concepts pertaining to the phenomenon (Strauss and Corbin, 1990).

The natural setting and the family as the unit of interest

The decision to conduct a study in the natural setting, which in this case was the family in the family home, acknowledges the overarching importance of the context within which the young person's bed wetting is managed from day to day. It acknowledges that something of the reality of bed wetting for the individual family members and the family as a social unit would be lost if the conversations were conducted out of context, for instance if conversations were conducted with only one family member or outwith the home.

The researcher as the principal data gathering instrument

The purpose of a naturalistic inquiry is to elicit the meaning or perception of an experience from the participant's point of view (the emic perspective) rather than from the researcher's perspective (the

etic perspective). As Lincoln and Guba (1985) point out, it would be virtually impossible to devise *a priori* a non-human instrument with sufficient adaptability to encompass and adjust to the variety of realities that are likely to be encountered in the natural setting. In a naturalistic inquiry the human instrument, with all its imperfections, is the natural choice because of its adaptability and reflexivity:

"All instruments interact with respondents and objects but ... only the human instrument is capable of grasping and evaluating the meaning of that interaction."

Lincoln and Guba (1985) p.39

Lincoln and Guba argue for the legitimization of tacit (unspoken) knowledge which may be perceived intuitively by the researcher, that is without conscious reasoning or analysis, as well as knowledge gained in language form. They suggest that the nuances of multiple realities can only be appreciated in this way. They propose that much of the interaction between the researcher and the participants occurs at an intuitive level, as it does in everyday life. External verification of the knowledge gained in this way is not possible (Section 3.10). The inability of a conversation transcript to capture the totality of an interaction is acknowledged (Section 3.7.2).

The use of supplementary data collection methods

"The goal of qualitative research is to document and interpret as fully as possible the totality of whatever is being studied in particular contexts from the people's viewpoint or frame of reference. This includes identification, study and analysis of subjective and objective data in order to understand the internal and external worlds of people."

Leininger (1985b) p.5

In answer to the question "Can qualitative and quantitative methods be combined?" Denzin (1978), Jick (1983), Mitchell (1986), Tripp-Reimer (1985) and Strauss and Corbin (1990) among others (who have used predominantly qualitative methods in their own research) say that methods can be combined, although most research which combines methods is designed in such a way that emphasis is placed much more on one approach to data collection than the other, as in this study.

In a discussion of study design issues relating to the linking of qualitative and quantitative data, Miles and Huberman (1994) suggest that the issue is one of knowing when it is useful to count and when it is difficult or inappropriate to count at all.

As Salomon (1991) points out, the issue is not a debate about the usefulness of quantitative versus qualitative methods *per se* but about whether the researcher is taking a positivist approach to understanding a few variables or a holistic approach to understanding the interaction of a multiplicity of variables in a complex environment. In their advice to researchers on designing a predominantly qualitative study, Miles and Huberman (1994, p.43) caution against falling into a "default" mode in which collecting qualitative data is seen as the only way of proceeding.

In addition to the principal data gathering methods described in Section 3.7.2 which involved in-depth conversations with families, three supplementary methods of data collection were incorporated into this study's design for very specific purposes (Section 3.7.3). These were:

- a urinary symptom questionnaire (Appendix I), completed by the family before the researcher's first visit
- diaries (Appendices II and III), in which the young person and his or her principal carer recorded events over a one month period as they actually happened and their feelings at the time
- a check list of methods used by families in the past to encourage the young person's bed wetting to stop (Appendix IV), completed by the researcher in consultation with the family, at the conclusion of the last visit.

Each of these three methods can be used as a primary data collecting method in itself and each has a large body of methodological literature associated with it. There is not, however, the space here to discuss the nuances and subtleties of these methods or specific design issues. Texts regarded as authoritative works, such as Oppenheim's (1992) book on questionnaire design, were consulted and due care and attention was taken with the design of the tools used. Their design and content were discussed in depth with supervisors and clinicians locally, many of whom had considerable experience of research methods more generally (Section 3.4). The ways in which these tools were used in practice are described in Section 3.7.3.

Sample Selection

In quantitative research studies considerable attention is usually given to obtaining a sample which is statistically representative of the population of interest, so that generalisations may be made from the study. This is achieved through various procedures such as simple random sampling, stratified sampling, multi-stage sampling and so on (Kirkwood, 1988; Kanji, 1993; Vogt, 1993).

Quite a different approach is taken in a naturalistic inquiry. Random or representative sampling is not used because the researcher's concern is not to generalise the findings of the study to a defined population but to maximise discovery of the heterogeneous patterns and problems that occur in the particular context under study (Erlandson et al, 1993). Two common approaches, which may be used in the same study and were used in this one, are selective sampling and theoretical sampling (Erlandson et al, 1993; Gilgun et al, 1992; Marshall and Rossman, 1995; and Strauss and Corbin, 1990). The nature and processes of selective and theoretical sampling used in this study are described in Section 3.6.

3.4 The consultation phase

After identifying and delineating the research questions, deciding on the overall research approach and the specific methods that would be used to seek answers to them, there followed a three month consultation period with health care professionals locally (Figure 1).

The purposes of this consultation period were:

- 1) to inform all those involved directly or indirectly of the proposed study
- 2) to seek comments on the study's overall design and the design and content of the proposed data collection tools (Sections 3.7)
- 3) to identify the ethical issues associated with the study and to explore mechanisms for handling any issues which might arise, using local procedures (Section 3.5)
- 4) to discuss mechanisms for sample selection (Section 3.6)
- 5) to establish rapport and channels of communication with the clinicians who could be involved in sample selection and enrolment and who would continue to be responsible for the families' care after the study was over

- 6) to orientate the researcher to the methods for managing bed wetting advocated and used by health care professionals locally.

To these ends a number of meetings was arranged with: the Chief Nursing Advisor, Primary Care Manager and Chief Statistician at the Health Board; members of the GP Research Group; a senior consultant urologist and the health visitors in the proposed study area.

The advice and support of health care professionals locally proved invaluable. Through their wholehearted and enthusiastic co-operation, the health visitors greatly facilitated sample selection and enrolment (Section 3.6). Returning to the health visitors and the GPs of the families who participated in the study, with the insights gained from it, is one of the researcher's highest priorities for the further dissemination of this study's findings (Figure 1). The interest and help of all those health care professionals approached, during this study's consultation phase and afterwards, is gratefully acknowledged (Acknowledgements).

3.5 Ethical issues

3.5.0 Introduction

"... ethics pose particular problems to nurse researchers in some situations because ethical requirements sometimes conflict with the rigors of the scientific approach."

Polit and Hungler (1989) p.23

This section focuses on the main ethical issues associated with this study. The issues can be thought of in two broad categories:

- (1) Issues of universal concern for research involving human subjects such as informed consent, privacy, confidentiality and data protection
- (2) Issues which are more study specific.

Transcending all of these issues is the overarching issue of beneficence, which is discussed first.

3.5.1 Beneficence

Beneficence has connotations of active goodness, yet in the context of a discussion of the ethics of research it is more usually taken to mean doing no harm or preventing harm, that is non-maleficence. As no research study can honestly be claimed, in advance, to be entirely risk free, taking cognisance of the principle of beneficence means in practice balancing anticipated risk against potential benefit at both the individual level and the level of the greater good (Holm and Llewellyn, 1986).

Before the Second World War the ethics of research and experimentation with humans was unregulated. Public knowledge of the atrocities uncovered during the Nürnberg trials raised awareness of the potential and actual dangers of research involving humans and led to the Nürnberg Code of 1947. This was the first set of ethical standards for judging biomedical research proposals. This set of principles was followed by the Declaration of Helsinki of 1961 which addressed issues relating to clinical research carried out within the context of professional care.

Most professional groups now also have their own code of research ethics. For nurses ethical issues relevant to both practice and research are embodied in the United Kingdom Central Council for

Nursing, Midwifery and Health Visiting (UKCC, 1989) publication *Exercising Accountability* which includes the responsibility of duty of care. This responsibility is also embodied in both civil and criminal law as well as in nurses' code of professional conduct (UKCC, 1992). There is not a UKCC code of ethics relating specifically to the conduct of nursing research. The particular responsibilities and issues for nurses undertaking research are, however, explored and explained in many articles and texts such as Clarke (1991), Fowler (1988), Fry (1981), Johnson (1992) and Hunt (1994). Gillon (1991) explores more general issues relating to research and health care.

The dimensions of beneficence and the issues arising from attempting to put this overarching principle into practice are described below.

3.5.2 Informed consent

Gaining the informed consent of participants is an issue of universal concern when enrolling human subjects into a research study of any kind. In essence informed consent means the knowing consent of an individual (or a legally authorised representative), who is able to exercise free power of choice to participate in a research study, without undue inducement or duress. The basic elements of informed consent are summarised in Table 2 and these were the guiding principles behind the letter sent to families given at Appendix V. More detailed accounts of the issues surrounding the rather complex construct of informed consent are to be found, for instance in Bulmer (1993), Homan (1991) and Macmillan (1987) as well as in the texts relating to nursing research previously cited.

TABLE 2 The basic elements of informed consent

(based on Holm and Llewellyn (1986, p.233) and Polit and Hungler (1989, p.24))

1. A statement that the study involves research
2. An explanation of the topic and the purposes of the research
3. A statement of the expected duration of the participant's involvement
4. A description of the nature of the participant's involvement
5. A description of any foreseeable risks or benefits to the participant
6. A statement of procedures relating to confidentiality
7. A named person to contact and a means of contacting them for answers to any questions about the research
8. A statement that participation is voluntary and that refusal to participate will not affect the participant's entitlement to care or result in any other penalties
9. A description of the possible benefits to others which may reasonably be expected as a result of the research having been undertaken

Archbold (1986), Erlandson et al (1993), and Marshall and Rossman (1995) describe the particular challenges and ultimately the impossibility of obtaining the fully informed consent of participants prior to their enrolment into a naturalistic inquiry:

"At the beginning of a project, the researcher does not know all that he or she is looking for. The project develops and changes with ongoing data analysis ... A second problem ... is that the researcher does not want to influence the subject's behaviour or responses by explaining in detail what is being studied".

Archbold (1986) p.158-159

It is actually impossible to tell the participant "everything" at the start of a qualitative research study because the researcher does not know what will emerge as being particularly important. It is perhaps more useful to conceptualise overt versus covert presentation of the research to the participant as being on a continuum. Archbold (1986) suggests that the extremes of pure overt presentation (telling everything) and pure covert presentation (telling nothing) do not exist (unless the participant has not been informed of the research at all). Nevertheless, issues relating to covert research have and do exercise many researchers as described by Bulmer (1993), Homan (1991), Johnson (1992) and Mitchell (1993).

In the present study the initial broad research questions, outlined in Section 3.1, were explicitly stated in the letter to families (Appendix V). In reality many more topics were explored with the families as they emerged, as is reflected in Chapters 5 and 6. The families' recognition of the inquiry as a legitimate area for a nurse to research and the families' responses to being involved in the study are discussed in Section 3.7.2. Certainly the research was conducted in the spirit of beneficence and in practice the researcher re-negotiated and expanded the basis of the participants' informed consent at each encounter. This is sometimes described as serial consent.

Participants were told at the outset that they were free to discontinue a conversation with the researcher at any time, without giving a reason. No participant chose to do so in practice. Special care was taken to explain this to the young people who took part in the study, in language appropriate to their age, using a form of words such as: "If I ask you about something and you don't want to tell me about it, you don't have to tell me, and that's all right".

There are special issues relating to the competence of potentially vulnerable subjects, such as the frail institutionalised elderly and the mentally ill, to give informed consent. "Vulnerable subjects" is usually taken to include children (Gillon, 1991; Grodin and Glantz, 1994). A consent form was designed specifically for the young people but in the end it was not used. Following discussion of this issue at the Ethics of Research Committee meeting which dealt with the submission it was decided to ask for the written consent of the young people aged 16 years or over on the parents' consent form, as shown at Appendix V.

3.5.3 Privacy, confidentiality and data protection

Polit and Hungler (1989, p.25) describe the central issues surrounding the matter of privacy:

"Virtually all research involving humans constitutes some type of an intrusion into someone's personal life ... The procedures used to obtain the information, and the information itself, should not be used to the disadvantage of the person providing it. Whatever information a researcher obtains in the course of a study should be considered privileged information and should under no circumstances be publicly disclosed in a fashion that would identify any specific person."

A study of family members' experience of any phenomenon conducted in the natural setting (often in their own home), could be considered to be the ultimate intrusion into people's personal lives as the very purpose is to uncover the reality of the experience from the family members' own perspective. Two mechanisms for protecting participants' privacy are *anonymity* and *confidentiality*.

In a study such as this anonymity cannot ultimately be guaranteed as the researcher comes to know the participants through prolonged personal contact and knows where they live, but the study was designed to ensure the families' anonymity until they had consented to take part, through the agency of the health visitor who addressed and sent the letter telling the family about the study or who delivered it in person to the family home (Section 3.6.3).

Issues relating to confidentiality were outlined in the letter to families and a direct telephone line, dedicated for the study participants' exclusive use, was installed into the researcher's own study at

home (Appendix V). The researcher's office in the parent research institution was felt to be too public as it was shared with two colleagues and there were many people passing in and out, including under-graduate nursing students.

Each family was assigned a study number which was used to identify them on transcripts and on supplementary data forms. All documentation and audio tapes were kept in a locked filing cabinet. In this thesis pseudonyms have been used throughout and the families were assured of anonymity in the reporting of the study's results.

3.5.4 Role conflict

An issue, which has troubled many nurse researchers on a personal level (e.g. Dunn, 1991; and Wilde, 1992) is the issue of role conflict, that is the conflict between researcher as nurse and nurse as researcher.

When conducting a phenomenological inquiry into the meaning of battering to women who had been victims, Dunn (1991, p.388) found the experience emotionally draining:

"...the qualitative researcher is usually not prepared to deal with the stress, deep personal involvement, role conflicts, discomfort, and the physical/mental effort that arises from such research."

She expressed the view that these experiences could affect data analysis. Wilde (1992) also described issues of role conflict which arose during a qualitative study whose purpose was to explore critical factors influencing nurses' perceptions of their performance in specific situations. McHaffie (1988) tells a more positive story, which relates more closely to the researcher's own experience (Section 3.7.2). It would seem that the nature of the experience of being a researcher who is also a nurse varies, and could be affected by a number of factors such as the personal qualities of the researcher, the nature of the topic under study and the researcher's "comfort" in the situation. This could in itself be an interesting topic for a grounded theory study. The theme of nurse as researcher is developed further in Section 3.7.2.

3.5.5 Ethical issues relating to research involving young people who wet the bed

Suspected child abuse

The possibility of encountering child abuse was anticipated. A search of the literature suggested that the punishment of children who wet the bed was uncommon, but not rare (Section 2.2.3).

Mechanisms for referral in the case of suspected child abuse were discussed with clinicians during the consultation phase (Section 3.4). The Region's Inter-Agency Procedural Guidelines were adopted. Only one case of child abuse was knowingly encountered. The abuse had occurred in the past and at the time of the study the perpetrator had been in prison for the offence for 18 months.

Discovering an unmet medical need

The other issue anticipated in advance of meeting with the families was discovering an unmet need for medical care. Criteria for referring a family back to their GP for further assessment of urinary continence problems were discussed with some of the GPs in the GP Research Group, including the group's Chairman, and with a senior consultant urologist (Section 3.4). It was jointly decided that specific referral criteria would be haematuria or a suspected urinary tract infection. It was agreed that requests for further information about the management of bed wetting or any other clinical issue would be passed back to the health visitor, in the first instance, with the family's consent.

Raising the spectre of a problem with no ending

Both ethical and theoretical considerations influenced the decisions taken during the process of data gathering to pursue some lines of inquiry and not others (Section 3.7.2).

It was quickly recognised that many parents and young people had come to regard the bed wetting as a never ending problem and had come to believe themselves to be helpless to influence the situation. In a few instances parents and young people expressed feelings of both helplessness and hopelessness (Sections 6.3.2 and 6.4.2). Great care was taken not to raise the spectre of the possible long term nature of the bed wetting within those families where this issue had not spontaneously emerged.

3.6 Sample selection and enrolment

3.6.0 Introduction

The approach to sampling in a naturalistic inquiry is rather different from the approach adopted in many quantitative studies (where random representative sampling is used) because ultimately the sampling is on the basis of concepts that are thought to be particularly relevant to the evolving theory, rather than on the basis of a few characteristics of the study participants specified in advance as being important.

Sampling in qualitative research is a dynamic process in which the researcher is responsive to new concepts as they emerge. In a grounded theory study sampling continues until theoretical saturation is reached (Glaser and Strauss, 1967; Glaser, 1978) (Section 3.6.2).

The processes of selective and theoretical sampling are described below.

3.6.1 Selective sampling

Selective sampling precedes theoretical sampling for several reasons. The first reason is pragmatic. In order to gain access to a sample at all it is necessary that the research proposal be approved by an Ethics of Research Committee which usually requires a clear specification of the sample and the method of recruitment to the study. Although naturalistic inquiry requires that the researcher suspend his or her commitment to *a priori* views of the phenomenon, an investigator is highly unlikely to be without ideas about the kind of subject most likely to provide information about the phenomenon being studied. This may be because of personal or professional experience, which may have kindled an interest in the phenomenon in the first place. Ideas may also come from the review of the literature required to ensure that the knowledge being sought is not already publicly available. It is, however, important that the researcher is explicit about any preconceived ideas held at the outset of the study.

The information requested by the local Ethics of Research Committee is given in Appendix VI. This makes the researcher's views prior to the commencement of data collection quite explicit. The inclusion and exclusion criteria employed during initial selective sampling are given in Table 3. They were based on the initial review of the literature on bed wetting (Section 2.2), a discussion with supervisors and the advice of health care professionals locally (Section 3.4).

It was decided to recruit families, known to the GP or health visitor, which included one or more young people known to wet the bed, living at home with one or both parents.

The age of five years was initially selected as the age from which to recruit the young people because of the consistency with which bed wetting was defined in the literature as being a problem from that age (Section 2.2.1). The criterion of "seven wet nights in a two week period" was used as this was the criterion proposed by Butler (1991) in his paper: *Establishment of working definitions in nocturnal enuresis* (Section 2.2.1).

It was decided to limit the diversity of the sample by excluding young people who were wetting the bed as the result of a mental or physical illness of sufficient severity to require them to be attending a special school or to be receiving care exclusively at home. Young people living in institutionalised care, such as a children's home or boarding school were also excluded (Table 3).

It was decided not to exclude young people where the cause of the bed wetting was known, if they were attending a normal school. The inclusion of a "deviant" case, that is one young person where the cause of the bed wetting was known for certain, proved illuminating (Chapters 5 and 6).

3.6.2 Theoretical sampling

Theoretical sampling is sampling on the basis of concepts that have proven theoretical relevance to an evolving grounded theory, either because they are repeatedly present or notably absent when incidents are compared. The aim of theoretical sampling is to sample events rather than people *per se* to gain more understanding of: the range of conditions that give rise to the actions or inaction; how these conditions change or stay the same over time (their stability), and the consequences of these actions or inaction.

TABLE 3 The inclusion and exclusion criteria employed during initial, selective sampling

| | |
|---------------------------|--|
| Inclusion criteria | <p>Families with one or more young people who have primary or secondary nocturnal enuresis, and who:</p> <ul style="list-style-type: none">• are aged 5 - 20 years old, and• live at home, with one or more parents, and• experience at least seven wet nights in a two-week period, and• are known to the family's health visitor or general practitioner |
| Exclusion criteria | <p>Families where the young person with nocturnal enuresis is sufficiently mentally or physically ill or handicapped to be:</p> <ul style="list-style-type: none">• attending a special school or day-care facilities for the mentally or physically ill or handicapped, or• receiving care exclusively at home <p>Young people living in institutionalised care, such as a children's home or boarding school, for at least part of the time</p> |

During the initial sampling phase the purpose is to uncover as many potentially relevant categories and concepts as possible. At this stage the researcher is open to all possibilities and may aim to gain access to the greatest diversity of people and situations. Later the sampling becomes more focused as the emphasis shifts towards theory closure, that is as categories become saturated and the relationships between concepts that have emerged as central to an understanding of the phenomenon are verified.

In the light of the early data analysis in this study, when it was rapidly becoming clear that many families had regarded the young person's bed wetting as a problem long before the young person had reached the age of five years old, the lower age limit for inclusion into the study was dropped and a four year old girl and her family were recruited. For similar reasons the frequency of bed wetting of "at least seven nights in a two week period" was dropped and four young people were recruited who were wetting the bed one night per week or less at the time of the study (Section 4.3).

Recruitment continued until 19 families and 20 young people who wet the bed had been enrolled. By this time the concept of "perceived helplessness", which was thought to be the core concept had been identified, the main categories were saturated (no new information or insights were coming to light) and the relationship between many of the concepts was becoming clear. Data analysis continued for a number of months after the last family was recruited (Figure 1). During this time hypotheses were constantly being compared against the data (Section 3.9).

3.6.3 The enrolment process

Families thought to meet the study's inclusion criteria (Table 3) were identified by health visitors, with the help of the sample selection form (Appendix VII). This form was completed by the researcher in consultation with the health visitor at an informal meeting. As described in Section 3.6.2 the inclusion criteria were soon dropped but this proforma was still used as it was found to be a helpful way of summarising some basic contextual data and keeping a track of the number of consent forms and letters that had been sent out.

In order that the researcher would not know the identities or addresses of families, unless they consented to take part in the study, the researcher gave the health visitor:

- a recently dated but non-personalised letter explaining the nature of the study and its purpose (Appendix V)
- a consent form, to be completed by parents and the young person if aged 16 years or over, if they agreed to take part (Appendix V)
- a stamped envelope, addressed to the researcher at the researcher's academic institution.

These were contained in a blank envelope which the health visitor was asked to address. The health visitor then decided whether to post the letter to the family or to deliver it by hand at her next visit. This mechanism, recorded on the sample selection form (Appendix VII), was decided upon by the health visitors themselves (Section 3.4).

In total 51% of families identified by health visitors who were sent or given the letter about the study, agreed to take part. This is very close to the estimate made on the submission to the Ethics of Research Committee (Appendix VI).

3.7 Data collection

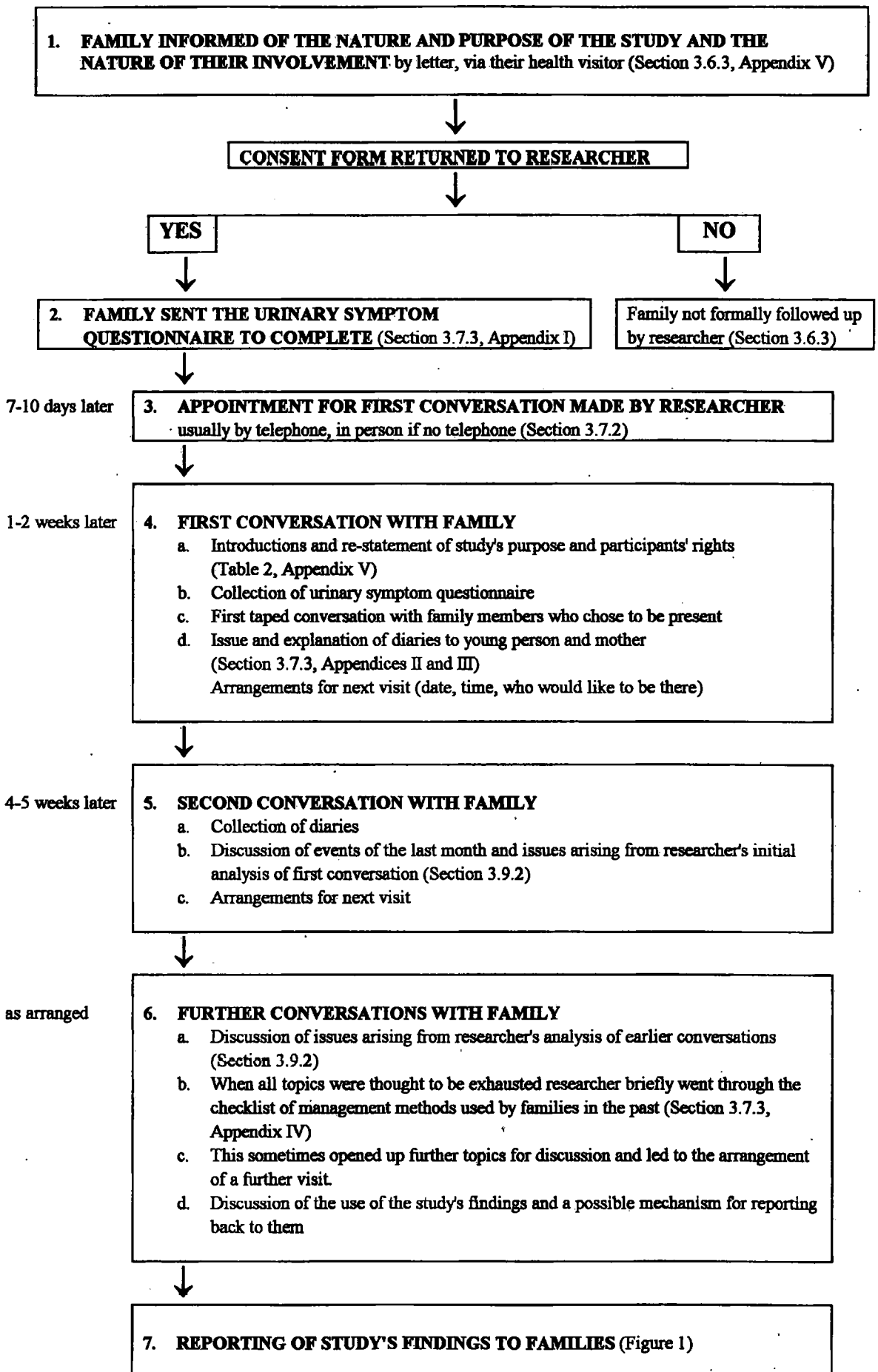
3.7.0 Introduction

This section begins with an overview of the data collection process and the nature of the involvement of families (Section 3.7.1). Some of the challenges and techniques of informal, in-depth interviewing are described in Section 3.7.2 with special reference to the challenges of having conversations with children and adolescents. The purposes and uses of supplementary data collection methods are described in Section 3.7.3.

3.7.1 An overview of the data collection process

The nature of the involvement of families is illustrated in Figure 2. The sequencing of the use of supplementary data collection methods (Section 3.7.3) is indicated in this flow chart. Steps 1-4 were common for all families. After the first conversation the nature and duration of the families' involvement varied.

FIGURE 2 The nature of the involvement of families



In one case, where an eight year old boy had been dry at night for two weeks between the completion of the urinary symptom questionnaire and the researcher's first visit, the decision was made that the researcher would not return and the young person would not be asked to keep a diary. This decision was made on ethical grounds for fear of setting back the progress made by emphasising a problem which seemed to have resolved. In all other cases the researcher revisited the family at least once and usually twice. In three cases the family was visited on four occasions, by mutual agreement.

The families were encouraged to decide for themselves who would be present during the conversations with the researcher. In many cases their decisions were revealing of the nature of the involvement of different family members with the young person's bed wetting, of the division of tasks within the household and of the way that the family chose to present itself to an outsider.

In many families there was evidence that a decision to become involved in the study had been carefully talked through between the parents and the young person:

"Mrs I: I explained to him when we were filling in the form (the urinary symptom questionnaire), if he wanted to, and I said he didn't have to and he said he doesn't mind, plus it could help somebody else or help others."

Mother of Ian (age 13) 196/70 p.1-2

In a number of cases the researcher and the young person were left together to have a conversation when the mother left the room on the pretext of making coffee or seeing to some domestic chores in another part of the house.

Obtaining access to participants involved a continuous process of negotiation and re-negotiation. In practice, the arrangements associated with the researcher's visits were for the most part controlled by the mothers. In three families the arrangements were rather haphazard in that the mothers had forgotten about the arrangements made and happened to be in when the researcher called.

3.7.2 The conversations with families

3.7.2.0 Introduction

"Asking questions and getting answers is a much harder task than it may seem at first. The spoken or written word has always a residue of ambiguity, no matter how carefully we word the questions and report or code the answers. Yet, interviewing is one of the most common and most powerful ways we use to try to understand our fellow human beings."

Fontana and Frey (1994) p.361

The principal method of data collection in this study was through in-depth informal interviews with families. The special challenges and techniques of informal, in-depth interviewing have been described in detail in many articles and texts on research methods, such as Barker (1991), Chenitz (1986), Fielding (1993), Fontana and Frey (1994), Gilgun et al (1992), Gray (1994), Hague (1993b), Jones (1985), May (1991), Oppenheim (1992) and Rose (1994). There is not the space here to dwell on all of the issues raised in these books and articles. Instead attention is given to some issues of particular relevance to this study, such as the communication skills which may be brought to conversations with families by a nurse (Section 3.7.2.1), the special challenges of interviewing children and adolescents (Section 3.7.2.2), the challenges posed by the presence of younger children (Section 3.7.2.3) and the researcher's relationship with families as a fellow human being (Section 3.7.2.4).

3.7.2.1 Some consequences of the principal data gatherer being a nurse

Many of the skills required for conducting in-depth interviews such as: building rapport; active listening; open-ended questioning; restating and seeking clarification; focusing and summarising and paying close attention to non-verbal communication are also the skills required for effective communication in nursing practice, as described for example by Burnand (1989), Coutts and Hardy (1985) Ewles and Simnett (1992), Heron (1991), Porritt (1990) and Tschudin (1991). A nurse may well come to research with well developed inter-personal communication skills which are of pivotal importance when communicating with research participants.

Chenitz (1986, p.85) describes another advantage of being a nurse:

"The nurse image can be very useful to gain the confidence of informants. People identify nurses with a caring, nurturing role. Further, people will talk to nurses and reveal to them content that they may not be so willing to disclose to others."

There are, however, heavy responsibilities and ethical issues relating to the researcher who is known to be a nurse, of which perhaps the most central is the participants' expectation that the researcher will intervene in a clinical role should this be needed (Chenitz, 1986; Dunn, 1991; Wilde, 1992). It was for this reason that the researcher discussed her non-clinical role with the families at the outset and always referred the family back to the health visitor for specific advice, when this was sought (Section 3.5.4). This position was readily accepted by the families, who for the most part seemed glad to have the opportunity to discuss their feelings with someone who was not directly involved with their care.

3.7.2.2 The particular challenges of conversations with children and adolescents

In the past researchers have relied almost exclusively on adults (usually parents or teachers) as the primary informants for data concerning children's thoughts and feelings (Broderick, 1993; Faux et al, 1988; Stafford and Bayer, 1993):

"The traditional socialization and developmental perspectives view children as being unable to describe and understand their world and life experiences due to developmental immaturity (cognitive and linguistic) and to a lack of socialization experiences."

Deatrick and Faux (1991) p.203

However there are those, such as Amato and Ochiltree (1987) who view children as competent interpreters of their world:

"Overall, our data suggests that if researchers stick to the here-and-now they can achieve articulate and informative responses from children about their families."

Amato and Ochiltree (1987) p.674

It is important, however, to recognise the limits imposed by children's cognitive, social and linguistic skills (Yarrow, 1960), which vary enormously along the developmental life span as well as between individuals (Hetherington and Parke, 1993; and Mussen et al, 1990).

The ability of the researcher to gain the trust of the young person and the researcher's range of interpersonal skills are if anything even more important when conducting research involving children than in research involving adults. This is especially the case when talking with the youngest children whose linguistic and social skills are likely to be least developed and who are most likely to exhibit anxiety of strangers. The researcher needs to be flexible and inventive and to have a sufficient understanding of children's developmental stage and language levels to stand any chance of entering into the child's world, even to a limited extent.

When conversing with the young people in this study time was spent in getting to know them, after a simple introduction of the researcher as a nurse who was doing a "project" about bed wetting. The idea of research as a "project" was explored in relation to projects that the young people were involved in at school, to facilitate the young person's understanding that a project was about "finding out more about something, which might be helpful to know". The researcher's status as a nurse may well have legitimised the inquiry in the young people's eyes as well as the parents' eyes.

To facilitate an exploration of feelings, many of the young people were asked to draw pictures of themselves in concrete situations such as on waking up to find the bed wet. They were then asked to tell the researcher about the picture to help remove any ambiguity and to encourage the young person to share his or her feelings. The sensitivity of the topic was to some extent anticipated. It showed itself most clearly in non-verbal behaviour.

To overcome linguistic barriers, especially for the very young children, cards were made of the faces scale developed by Andrews and Withey (cited in McDowell and Newell, 1987 p.215) (Appendix VIII). This scale was used by Anderson and Bury (1988) to gain insights into people's feelings about life 18 months after a stroke. In the present study the purpose of using the cards was to help the young people to explore feelings for which they might not have the words. The young people were asked what the faces signified to them and their responses were interpreted accordingly. The meaning of the fourth face is ambiguous. Some of the older children described it as being "between happy and sad", some as "no feelings", some as "grumpy".

In practice, many young people who were very shy about talking about their bed wetting were able to communicate graphically what their feelings were with the help of the cards and to indicate their perception of the feelings of other members of the household, in a way which showed that they were able to make fine discriminations. The cards were used to facilitate communication. Sometimes only one card was used and the cards were not used in any order. Many of the children regarded the cards as a game which they greatly enjoyed:

MOYA: How do you feel about taking part in this project?

JOHN: Happy.

MOYA: Why that one?

JOHN: Well, it's the first time I've ever been in a project with adults and that and I'm really happy. I've not done a project like this before. It's really good. I'm enjoying myself.

MOYA: What was the best thing?

JOHN: Doing the faces and the pictures."

John (age 8) 327/133 p.1

It is extremely difficult for an adult not to be in control of an interaction with a child yet the young people were encouraged from the outset to determine the agenda. To postpone talking about bed wetting, and to show the researcher what he could do, John, quoted above, had systematically emptied the contents of his school bag, reading a story that he had written, reading from his evening's reading assignment from school and reciting a hymn that he was learning for Easter.

Any leads given by the children were followed up, but sometimes a straight question such as: "Tell me about the bed wetting", which could lead to an illuminating response from a parent, and indicate areas of special concern, would lead to no more than a shrug of the young person's shoulders, which was in itself revealing.

3.7.2.3 The challenges posed by the presence of younger children

On a number of occasions the mothers decided to speak with the researcher before the young person returned from school. In many of these cases the mother was looking after other younger children at the time. This posed special challenges to the researcher's inter-personal and interviewing skills.

Often the mother was quite understandably distracted by the children's comings and goings, by demands for money to buy sweets, requests for help with dressing and toileting and other requests for attention. On many occasions, in some households, children from other families wandered in and out

of the room. Disputes broke out between the children over toys. One toddler came in screaming, having soaked himself from head to foot with the garden hose; another two and a half year old quietly succeeded in covering himself and his toys with Tippex fluid as his mother and the researcher were talking over coffee. Some of the younger children were fascinated by the presence of a stranger and came over to make friends. Others were fascinated by the recording equipment and seemed to derive much pleasure from investigating it. In some households the television was left on in the corner of the room, although nobody seemed to be watching it.

In four families in particular where the mother was looking after one or more children under school age, the researcher found herself in the dual position of being both interviewer and child minder, entertaining up to three other children with the help of coloured paper and pens, while attempting to talk with the young person who wet the bed. At these times the researcher had the feeling that she had truly entered into the family's rather chaotic world. Or perhaps it was that some of these mothers were happy to take the opportunity to sit quietly for a few moments while someone else entertained the children. The tranquillity achieved by the researcher as four toddlers were absorbed with their drawing was described by one, usually distracted mother as: "no' normal!"

3.7.2.4 The researcher as more than a human data gathering instrument

This section ends with a brief description of the researcher's relationship with the participants of this study as a fellow human being.

The conversations with both the children and their parents required all the skills previously learned by the researcher during six and a half years as a teacher and then as a nurse, including patience and adaptability. Above all, they required empathy and unconditional acceptance of all the family members, which is also, ultimately, the basis of any therapeutic intervention (Tschudin, 1991).

The children and their parents reciprocated in so many ways, most of all by sharing their experiences and feelings with the researcher over several occasions. Some of the children gave the researcher small gifts which they had made. One of the most touching gifts was a thank you card from one family signed: "From all of us".

The mother of the family who seemed the most uncomfortable about taking part in this study unexpectedly sent a note eight months later enclosing some diary forms that she had come across:

"Dear Moya,
May I take this opportunity in thanking you for helping with the bed wetting problem. Paul has been dry since the autumn, already it seems a long time ago and one forgets the past routines ... Your help did stop us getting bogged down in the problem."

Although every effort was made to minimise any potentially adverse effects for the young people and their families of participating in this study, there was no secondary therapeutic agenda and the families were referred back to their health visitor for specific advice. Talking about the situation openly within the family may have led family members to review their beliefs, feelings and behaviour towards one another.

In her study of gift-giving in the patient-nurse relationship, Morse (1991c) describes gift-giving as a complex phenomenon and suggests that gifts are given for many reasons. Using a type of ethnography called *ethnoscience* she identified five categories of gifts, gifts of: reciprocity; manipulation; gratitude or obligation; serendipitous gifts, and donations, which she suggests all serve different purposes for both the patient and the nurse. As a guide to how a nurse should respond to gift-giving Morse suggests:

"While the manipulative category of gifts are those that should not be accepted, gifts of gratitude and gifts of obligation should be accepted: the former is an essential part of the patient's recovery process, and the latter is a normative courtesy. The wise nurse knows the difference."

Morse (1991c) p.253

In this study the gifts given, whether tangible tokens, kind remarks, cups of coffee, or time out of a busy schedule, were accepted in the spirit in which they were given, with gratitude and a growing sense of humility on the part of the researcher.

3.7.3 Supplementary data collection methods

Issues relating to the use of supplementary data collection methods in a naturalistic inquiry are discussed in Section 3.3. In addition to the principal data gathering methods described in Section

3.7.2, which involved in-depth conversations with families, three supplementary methods of data collection were incorporated into this study's design for specific purposes and are described below.

The urinary symptoms self-complete questionnaire

"Quantities are of qualities, and a measured quality has just the magnitude expressed in its measure (*no more and no less*)"

Kaplan (1964) p.207 (this author's comment in italics)

Measuring a property of a phenomenon does not deny that the totality of the phenomenon may be much more.

A self-complete urinary symptoms questionnaire was sent to families in advance of the researcher's first visit to collect data about certain properties of the bed wetting itself (such as its frequency) and to collect some background contextual data (such as whether or not the young person who wet the bed shared a bedroom and if so with whom). The questionnaire and the instructions to families which accompanied it are given at Appendix I.

Although naturalistic inquiry requires the researcher to suspend commitment to *a priori* views of the phenomenon, in practice the researcher is highly unlikely to come to the study with no ideas about the nature of the phenomenon, either because of personal or professional experience, or through the review of the literature required to ensure that the knowledge being sought is not already available. In the present study certain properties of bed wetting such as its frequency (nights per week, and times per night) could reasonably be identified in advance as potentially important. What could not be anticipated at the start of the study was whether frequency of bed wetting would prove to be a significant factor affecting the experience of the phenomenon from the family's perspective.

As with the initial research questions and the initial selective sampling, this method of data collection was entered into in the knowledge that the method could be refined or even abandoned very early in the study if the data so collected proved to be of little significance. In the event the data proved enlightening in some unforeseen ways (Section 4.3).

A study such as this sheds most light on one moment in the family's life - the present moment - but historical data can also shed light on the dynamics of change itself at both the macro and the micro level. The data from the urinary symptom questionnaire acted as a valuable baseline prior to the researcher's first personal contact with the family. For seven of the young people there was a marked reduction in the frequency of the bed wetting during the study, expressed as nights per week (Appendix XIV).

The data collected about day time urinary symptoms, with the help of the questionnaire, also proved useful, in that they provided insights into the problems of maintaining secrecy outwith the family when a young person has poor day time control of bladder function. The data gathered about day wetting, through the questionnaire and in conversation also confirmed the converse, that monosymptomatic bed wetting could for the most part be kept as a family secret (Sections 5.3 and 5.4). The hunch that this data might be relevant was confirmed.

The contextual data relating to the sleeping arrangements in the home also provided insights about bed wetting, again in some unexpected ways, as described in Sections 5.2.3 and 5.3.1.

The questions themselves were critically examined for a logical sequence, for clarity and for face validity by a senior consultant urologist and by the study's supervisors. The purpose of the questionnaire was not to collect standardised information (one of the purposes of using a questionnaire in a survey) but to discover efficiently which aspects of the symptom of bed wetting might be important for the individual, prior to further in-depth exploration of these aspects in conversation.

The participants were asked to mark any questions which they did not understand. Only one mother said that she had had difficulty with one question which asked about how many times per night the young person woke up wet, because this was so variable. Further questioning of the mother about this revealed some insights into the mother's own night time activities (Section 5.1.1). The questionnaire was not piloted in the way that it would have been in a quantitative study (for instance

for test-retest reliability) but its usefulness was reviewed with supervisors after data had been collected from six families. As a result of this review it was decided to continue with its use.

The diaries

The young person and the parent who regarded him or herself as the principal carer were asked to keep a diary, for a minimum of two weeks but ideally for four weeks, to record events as they actually happened and their feelings about them (Appendices II and III).

Diaries have been used in a variety of studies to gain insights into the lived reality of a phenomenon, to study compliance with treatment regimes and to collect data which might be less accurate if recalled retrospectively. Examples of the use of diaries in studies relating to health care include: Irvine and Cunningham-Burley's (1991) study of mothers' concepts of normality, behavioural change and illness in their children; Murray's (1985) study of psychiatric illness in general practice; Norman et al's (1982) evaluation of health diaries as a strategy to aid compliance with medical treatment; Roghmann and Huggerty's (1972) study of health and illness behaviour in young families; Verbrugge's (1989) study of patterns of change in disability and well-being, and Wyman et al's (1988) studies of the psychosocial impact of urinary incontinence in women.

In this study the purpose of asking the participants to keep diaries was to gain insights into the lived reality of the phenomenon being studied. Some mothers used the diaries to express their feelings, as well as to record events and the nature of their involvement. This use of the diary proved to be particularly illuminating.

In total 14 of the 19 parents (74%) kept a record of the young person's bed wetting as they knew of it. Thirteen of the 14 parents used the diary forms issued by the researcher and 12 of the 13 parents (92%) kept the diary for three to four weeks (Appendix XV). One father continued with his practice of recording his son's wet nights in his Filofax. By mutual agreement one mother did not keep a diary because she said that she was uninvolved and unaware of her 16 year old daughter's night time activities. In one family it was agreed that neither the parent nor the young person would keep a diary because it appeared that the young person had stopped wetting the bed (Section 3.7.1). Three

families did not keep diaries, although they accepted the diary forms. Their explanations of the reasons for this added a dimension to the theory illustrated in Figure 29 (Chapter 7). The diligence with which the diaries were kept appeared to be unrelated to the frequency of the young person's bed wetting.

Thirteen of the 20 young people (65%) kept a diary for three to four weeks, with varying degrees of enthusiasm, which seemed to reflect their attitudes to their control over the bed wetting (Sections 6.4.2 and 6.6). Three young people did not keep a diary by mutual agreement. In one case the bed wetting appeared to have stopped, in another case the young person was keeping a chart for the health visitor in relation to his use of a body worn alarm, and in the third case the mother thought that her four year old daughter was too young to understand the chart. One young person did not keep a diary because his father had kept a record in his Filofax. The three young people (aged five eight and nine) whose parents did not keep a diary or any record themselves also did not keep a diary. The mother of the nine year old remarked that her daughter had "lost" the forms. These mothers had not supervised the keeping of the young people's study diary or other charts given to the family by health care professionals.

The checklist of management methods used by families in the past

"If you know what you are after, there is no reason not to plan in advance how to collect the information".

Miles and Huberman (1994) p.35

One of the original aims of the study was to determine the range of strategies and treatments that families had employed or participated in in the past to encourage the young person's bed wetting to stop. This aim was made explicit in the initial letter to families (Appendix V). Having reviewed the literature on the methods used in the treatment of bed wetting (Section 2.2.3) a checklist was drawn up of the most common methods (Appendix IV). This checklist was completed by the researcher with families at the end of what was judged to be the final conversation in that all topics had come to be exhausted.

The researcher sat beside one or more family members so that they could look at the checklist. By this means new topics were often opened up and insights gained into some sensitive topics which had not always emerged spontaneously in conversation. Sensitive topics alluded to in this way included the use of punishment. The researcher introduced the checklist by saying: "This is a list of methods which some people have used in the past. They are not necessarily good methods or bad methods, they are just methods that some people have tried. I am interested to know whether you have used any of these methods and what your experiences have been". For families who had used few methods in the past the checklist was rapidly completed. However, sometimes the gaps shed light on why parents had chosen not to use a particular method or approach, which was often revealing of their attitudes to the young person and their beliefs about parenting more generally.

At an early stage the questions relating to the management of day wetting, which appeared at the end of the list, were totally dropped as they revealed so little information. When the topic of day time wetting was raised in conversation the researcher simply asked: "Did you do anything about it?" and the responses were subsequently coded on the transcript of the conversation.

The checklist was designed for easy use by the researcher, not for self-completion by the family. As with the urinary symptoms questionnaire, its use was discussed with supervisors after data collection with the first six families was completed. It was decided to continue using it in the way outlined because of the way in which it was facilitating the opening up of new topics when all topics of conversation, as identified interactively by the families and the researcher, seemed to have been exhausted.

3.8 The use of computer software to facilitate data storage and data handling

During the early design phase of this study, once it was known that most of the data gathered would be non-numerical and unstructured, questions relating to data storage and data handling were addressed, as is described below.

In their book *Basics of qualitative research: grounded theory procedures and techniques*, which formed an invaluable and much used guide during the analysis of data in this study, Strauss and Corbin (1990) barely mention the use of computer software to facilitate data storage, data handling and analysis. It is easy to understand, on an intuitive level, why some researchers feel that the use of computer software could stifle the creativity of the processes involved in inductive analysis. There is also the largely unspoken fear that a computer is like a genie in a bottle which, once released, will transform the activity of field research in unnoticed and unwelcome ways (Lee and Fielding, 1993).

In an article entitled "The right brain strikes back" Agar (1993) describes the dangers of what he calls "computer lust" (p.182) where the means become the end. In what he calls his paranoid fantasy he sees computers mutating from an item in a context to the context itself. The main counter to this argument is that the fault lies not with the computer software but with the researcher who uses it inappropriately.

Becker (1993, p.258) suggests that the use of computers for data analysis in grounded theory studies results in:

"...flat and over simplified descriptive results."

If the software were effectively left to itself this could conceivably happen but the use of computer software to facilitate theory generation and testing does not replace the right brain's ability to make conceptual connections from data from social situations that appear at first to be quite different. Instead, by facilitating and greatly speeding up the clerical tasks associated with data handling, it can free up the researcher's time (Tesch, 1990, 1991) to discover theory creatively and intuitively in the way that Glaser and Strauss (1967) originally conceived it.

The final decision to use a computer software package to aid data storage, data handling and some aspects of data analysis was taken after a careful analysis of the nature of the task in hand and an appraisal of the facilities provided by the software then available. With the stated and over-arching purpose of theory building very much in mind the following facilities were sought:

- a flexible coding system into which new codes could be added at any time
- the ability to view text retrieved in its context
- powerful search facilities
- a theory testing capability
- a way of keeping track of the project.

A search of the literature on the use of computers in qualitative research uncovered articles and books by among others: Anderson (1987); Gerson (1984); Huber and Garcia (1991) Knafl and Webster (1988); Morse (1991d); Pfaffenberger (1988); Richards and Richards (1991); Russell and Gregory (1993) and Tesch (1991). The most valuable books on the subject were found to be Fielding and Lee's (1993) book *Using computers in qualitative research* and Tesch's (1990) book *Qualitative analysis: analysis types and software tools*.

Almost any article or book on computer software is likely to be out of date in many aspects of detail before it is published as the field is moving forward so quickly. In an attempt to make a decision based on the most up to date information the major suppliers of software suitable for qualitative research were contacted for the latest information about their products.

A practical restriction on the choice of software was that the majority of computers available in the researcher's academic institution worked on the DOS rather than the MacIntosh operating system. Programmes which could only run on a main frame computer were excluded. It was hoped to find a programme that was user friendly, and which could be operated in Windows using a PC, and which could become part of a network at a later date should the study grow.

With this study's emphasis on theory building rather than description, the choice of software was eventually narrowed to The Ethnograph or NUD•IST. In the end the NUD•IST package was selected because of the power of its hierarchical indexing system, which is described in Section 3.9. NUD•IST stands for Non-numerical Unstructured Data: Indexing, Searching and Theorising. The NUD•IST version 2.3 (DOS) was trialled from December 1993 until the Windows Power Version 3.0 became available in the UK in March 1994.

One reason why NUD•IST appeared from the outset to be and has proved to be so appropriate for this study is that it was designed by Tom Richards for his wife Lynn, who has extensive experience of grounded theory methods of analysis and of conducting research with families.

Since the decision was taken to use NUD•IST there have been many valuable additions to the literature on the use of computers as an aid to qualitative research analysis. The availability of Miles and Huberman (1994) at the time when the selection of software was being made would have been especially helpful. A useful summary of programme characteristics is given in this book. An article by Richards and Richards (1994a) in Denzin and Lincoln (1994) gives a comprehensive exposition on the issues relating to the use of computers to facilitate a wide range of qualitative research approaches. Weitzman and Miles' (1995) book *Computer programmes for qualitative data analysis* is another authoritative text which gives insights into the use of computer software in qualitative research.

Ultimately a researcher's decision to use a computer programme to facilitate data handling and data analysis is a personal one and needs to be based on a thorough understanding of the purpose of the inquiry and an appraisal of the facilities of the different packages available at the time (Heise, 1988; Moseley and Mead, 1993; Richards and Richards, 1994b; Russell and Gregory, 1993; Walker, 1993).

The use of a computer software package can shift the balance of time spent on the mechanics of data handling *per se* and on data analysis, strongly in favour of data analysis, by considerably speeding up the clerical tasks involved in searching for and retrieving data. Gerson (1984) suggests that the

principal benefit of computer technology is its potential for increased rigour in analysis. Freeing up time and energy for the researcher to think creatively is perhaps one of the most compelling reasons for using computer software, especially when the time so spent leads to the development of a powerful, precise and tightly integrated theory.

The ways in which NUD•IST Power Version 3.0 has been used in practice to facilitate the mechanics of data storage, handling and data retrieval, and to aid analysis and theory development in this study are described and demonstrated in Section 3.9.

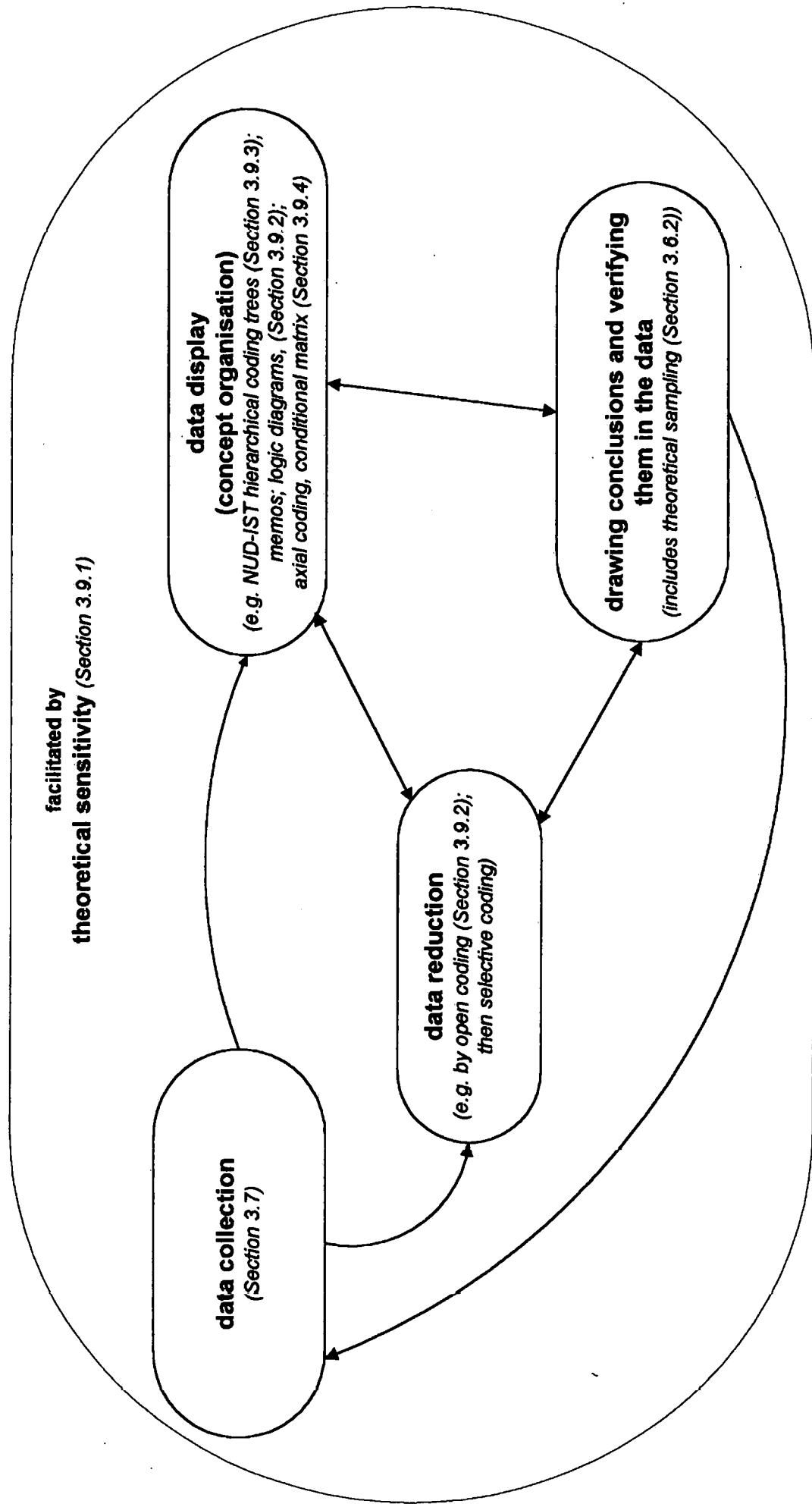
3.9 Inductive data analysis

3.9.0 Introduction

Induction is the essence of naturalistic inquiry and the basis of the grounded theory approach to data analysis. Induction involves the development of theory from data (Section 3.3). Concepts are ultimately the units of interest in grounded theory research. All the procedures described in this section have the purpose of identifying, developing and relating concepts. The analytic process is recursive. There is a constant interplay between proposing and checking. This is what makes the theory developed "grounded" in the data. An interactive model of the components of data analysis is given in Figure 3.

Before describing some of the analytic procedures used in this study a personal quality required of the researcher is described, which is central to the process of inductive analysis. The quality is sometimes referred to as "theoretical sensitivity" (Glaser, 1978).

FIGURE 3 An interactive model of the components of data analysis
(Modified from Miles and Huberman (1994) p.12 see Section 3.9)



3.9.1 Theoretical sensitivity

"Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't. All this is done in conceptual rather than concrete terms."

Strauss and Corbin (1990) p.42

Theoretical sensitivity is a requirement for the creativity which can help to uncover new ways of looking at a phenomenon. It comes from a number of sources. These include a knowledge of the literature (Chapter 2) and the professional and personal experience of the researcher (Section 1.2). These are the background that the researcher brings to the situation. Theoretical sensitivity can also be acquired through the analytic process itself. Insight and understanding increase as the researcher interacts with the data.

This is why it is so important to begin thinking about data from the start of data collection. One idea generates another, encouraging the researcher to look at data in new ways. Creative analytical thinking can be facilitated by writing memos and drawing diagrams to show tentative relationships between concepts (Section 3.9.2).

The key question to ask of the data is: "What is going on here?" Asking this question led to the analytic diagram (Figure 27) which held the key to understanding how young people and their parents might be interpreting each other's behaviour on "wet" mornings (Section 6.5.3).

Regarding all categories, explanations and tentative theories as provisional until convincingly supported by data, and following the coding procedures outlined below, has helped to give rigour to this study (Section 3.10). The appropriate use of existing research literature has also enhanced the researcher's theoretical sensitivity by helping to give meaning to data.

3.9.2 Open coding and the use of memos and diagrams

Open coding is the process of breaking down, examining, comparing, conceptualising and categorising data. The processes involved in open coding are described by Corbin (1986), Miles and Huberman (1994) and others. The purpose is to identify and name phenomena, which is a necessary first step in concept development.

From the time of the earliest analysis of the first conversations with families the emerging categories were identified and named. The coding was refined and new codes added in an ongoing way. Keeping a track of the coding was at first achieved by updating a loose leaf coding book with the aid of a word processing package (Word for Windows 2c). Six months into the study this tedious process was transformed with the help of the NUD•IST software package (Section 3.9.3).

Two analytic procedures which help with concept clarification are making comparisons and asking questions. These procedures were used constantly. This is what is meant when a grounded theory approach is described as a "constant comparative" method of inquiry (Glaser and Strauss, 1967).

Memos and diagrams were used as adjunctive procedures throughout the eighteen months of data analysis to help to explore the possible relationships between concepts, using techniques described by Glaser (1978); Corbin (1986); Miles and Huberman (1994) and Richards and Richards (1991, 1994b). An example of a memo written in the early stages of this study is given at Appendix IX. An example of a "story line" (a general descriptive account reflecting thinking about the study at a point in time) written to facilitate the identification and integration of emerging concepts is given at Appendix X. Examples of two logic diagrams used to help to achieve conceptual clarity are given at Figures 13 (Section 5.2.1) and 27 (Section 6.5.3).

3.9.3 Developing a hierarchical indexing system

The rationale behind the decision to use the NUD•IST Power Version 3.0 software to facilitate data storage and handling is given in Section 3.8. The facility to develop hierarchical coding trees to organise emerging categories and to help to explore the relationships between them was regarded as the feature which would help to bring order out of chaos (an anticipated mountain of data) and greatly facilitate the inductive analytical process.

Richards and Richards (1994b) liken NUD•IST's indexing system to a library index which enables the researcher to store and locate data very easily. If the indexing (coding) categories are organised hierarchically the result is an indexing tree which is like a map of the project. Each node on the tree

is like a pigeon-hole in which "like" data and the researcher's thoughts about them can be stored (Table 4). The software has been designed to enable the indexing system to grow and change shape as the researcher's thinking about a project grows and develops. At any point in time it shows the concepts being explored and it is therefore a reflection of the progress of the researcher's analytical thinking.

Over a one year period a hierarchical indexing system was developed to store the researcher's thinking about the project. The principal parent nodes are illustrated in Figure 4. Nodes one to five contain the data from the perspectives of the mothers, fathers, young people, siblings and health visitors who took part. Figure 4 illustrates the major sub-categories where data about facets of the mother's view were stored.

The sequence of the steps involved in data transcription, importing, coding, search and retrieval is illustrated in Figure 5 and the processes are described in Appendix XI. Following open coding the transcripts were systematically re-coded using codes developed throughout the year. A coding map (the index system) was available on the computer screen. It was also pinned to the researcher's study wall. This indicated the main indexing trees.

The individual trees were compiled in a loose-leaf coding book as well as being available on screen. A rigorous account was kept of the coding process for data from each family and "back-track" cards were developed and attached to transcripts whose coding had been entered before the new codes were created. These transcripts were then re-checked for the occurrence of these categories. The transcripts from the first three families to be coded were completely re-checked. For later families less back-tracking was required as there were fewer new codes. This process took many months, but through such close contacts with the data, over a prolonged period, theoretical sensitivity was enhanced and many new ideas were generated.

TABLE 4 Features of the node - the key component of the
NUD•IST hierarchical index system

| | |
|-----------------------------------|---|
| Definition | <p>A node is the point where a branch on the indexing system splits (see Figures 4, 7 and 8). Nodes are created, located and named by the researcher as places in the index system to store categories for data and ideas about the categories</p> |
| Features | <p>The date and time of the creation of each index node is automatically recorded by NUD•IST and this information can be retrieved, if required, to map the progress of the indexing system's development. Every node has:</p> <ul style="list-style-type: none"> • <u>a numerical address</u> - which specifies its location in the index system • <u>a title</u> - specified by the researcher <p>The title can be a conceptual title such as "mother as orchestrator" or a descriptive title such as "beliefs" or an <i>in vivo</i> title such as "we've been through all that".</p> |
| Optional features | <ul style="list-style-type: none"> • <u>a definition</u> - as decided by the researcher • <u>a memo</u> - in which the researcher can add free text remarks of any length in order to keep a record of thoughts and ideas about the category • <u>references to text units of data documents stored at the node</u> - as decided by the researcher after coding the text units |
| Text retrieval from a node | <p>The text indexed at a node can be retrieved at any time and can be searched for and sorted in a wide variety of ways, as illustrated in Figure 6 and described in Appendix XII</p> |

Note: All of the data attached to the node can be modified or deleted at any time. NUD•IST automatically dates the changes made.

FIGURE 4 The principal parent nodes in the NUD-IST hierarchical indexing system and the first level nodes under the mother's view

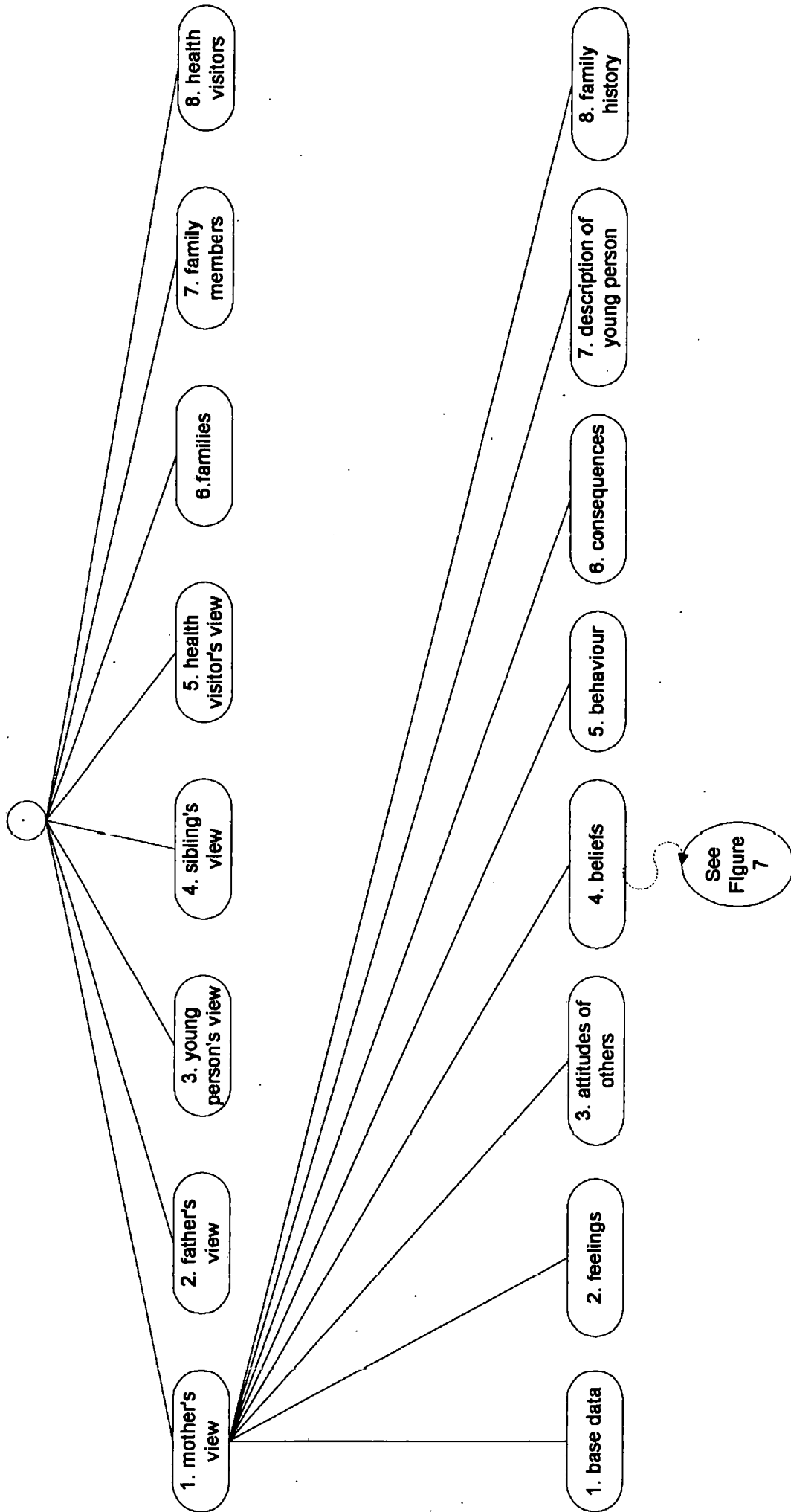
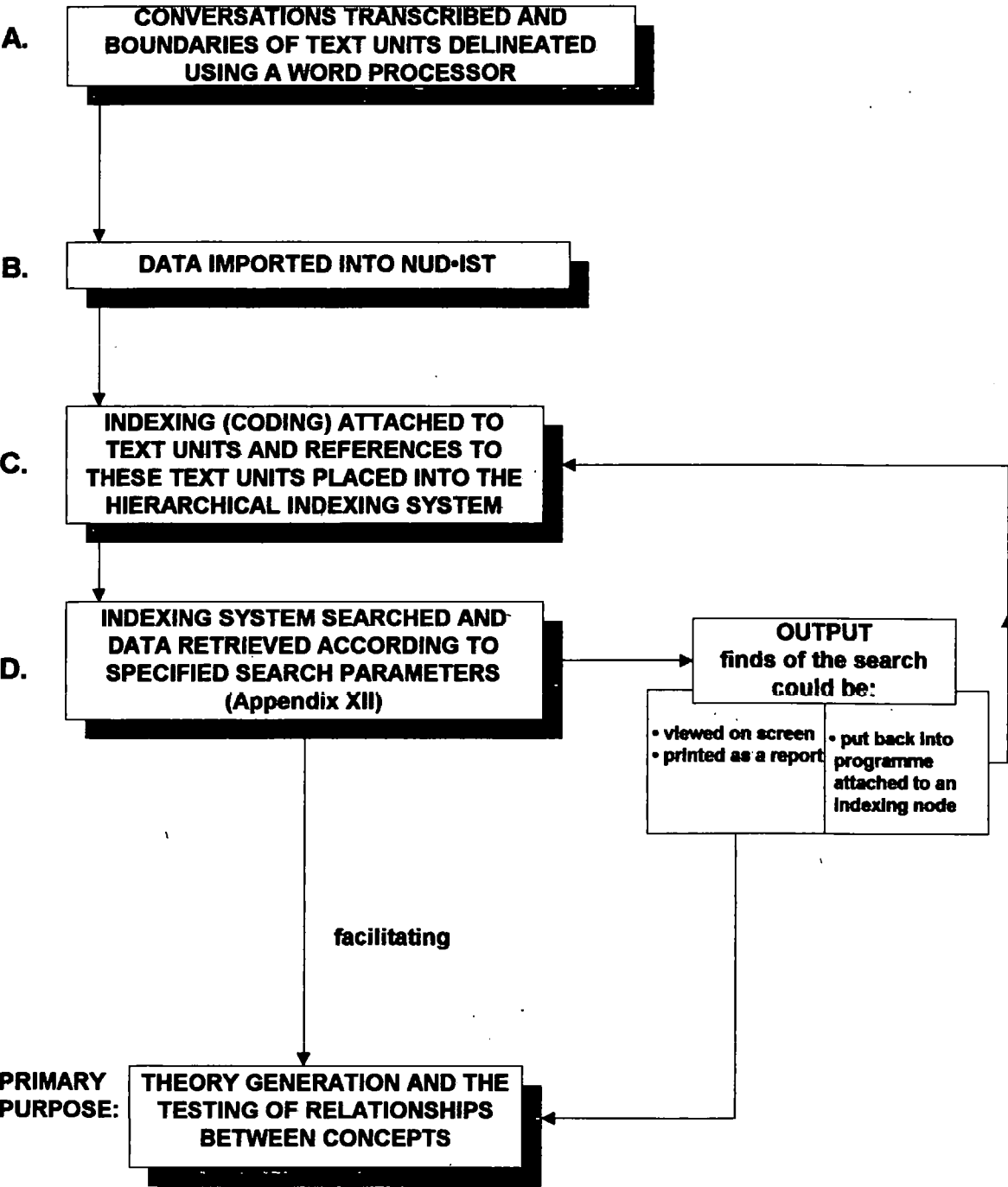


FIGURE 5 A flow diagram to illustrate the processes of data transcription, importing, coding, searching and retrieval using the computer software package: NUD-IST Power Version 3.0
(see also Appendix XI)



Lynn Richards regards the development of the indexing system and the coding (indexing) of data as much more than just a clerical exercise:

"Decisions are being made about what is a category of significance to the study, what questions are being asked, what concepts developed, what ideas explored, and whether these categories should be altered, re-defined, or deleted during analysis."

Richards and Richards(1994a) p.447

An indication of the powerful search facilities offered by NUD•IST is given in Appendix XII and is illustrated in Figure 6. Figure 6 is an *in vivo* print of an actual computer screen showing the whole indexing system at a point in time (small centre left tree), the part of the tree display being explored (centre tree), ways of modifying the index system itself (top centre column) and methods of searching the system (bottom right column). The operators and commands used most often in this study to search the indexing system and the data in it, are described in Appendix XII.

The way in which two small parts of the indexing system were developed is described below to illustrate the analytic processes involved.

Figure 7 illustrates part of the indexing system which emerged from mothers' comments on their beliefs about various aspects of the young person's bed wetting. The six sub-categories which emerged during conversations with mothers as important to them were the mothers' perceptions of:

- (1) the cause of the bed wetting
- (2) the young person's control over the phenomenon
- (3) the extent to which the young person was making an effort to be dry
- (4) the young person's desire to be dry
- (5) possible factors which might increase the young person's motivation to be dry, and
- (6) whether and when the young person would become reliably dry at night in the future.

The nature of these beliefs proved to be important determinants of parents' attitudes towards bed wetting (Chapter 6).

FIGURE 6 *In vivo* print of NUD-IST Index Tree Displays (summary tree and tree in use), IndexSystem Menu and Index System Search Operators (see section 3.9.3)

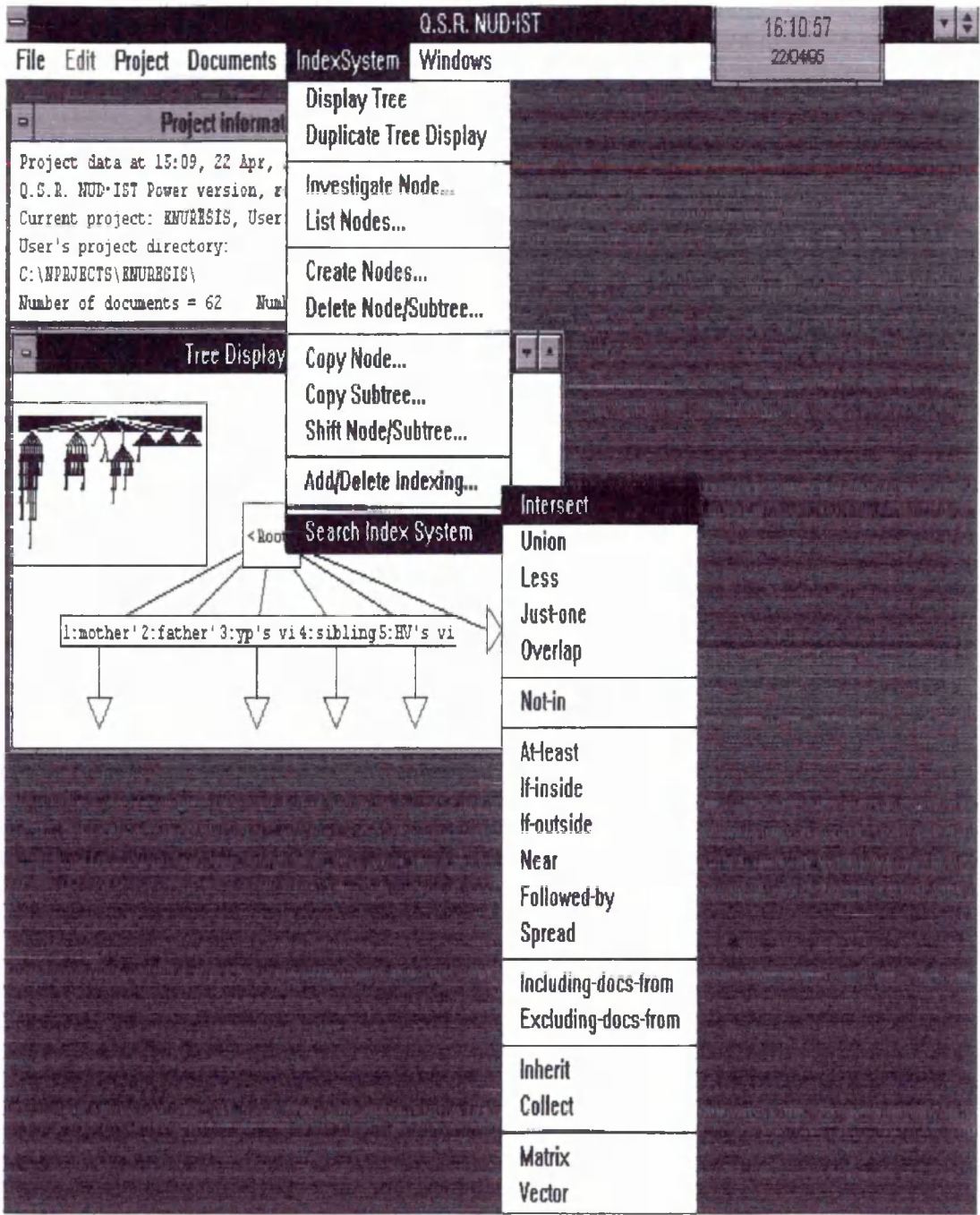


FIGURE 7 Part of the indexing system for mother's beliefs about bed wetting and parenting more generally

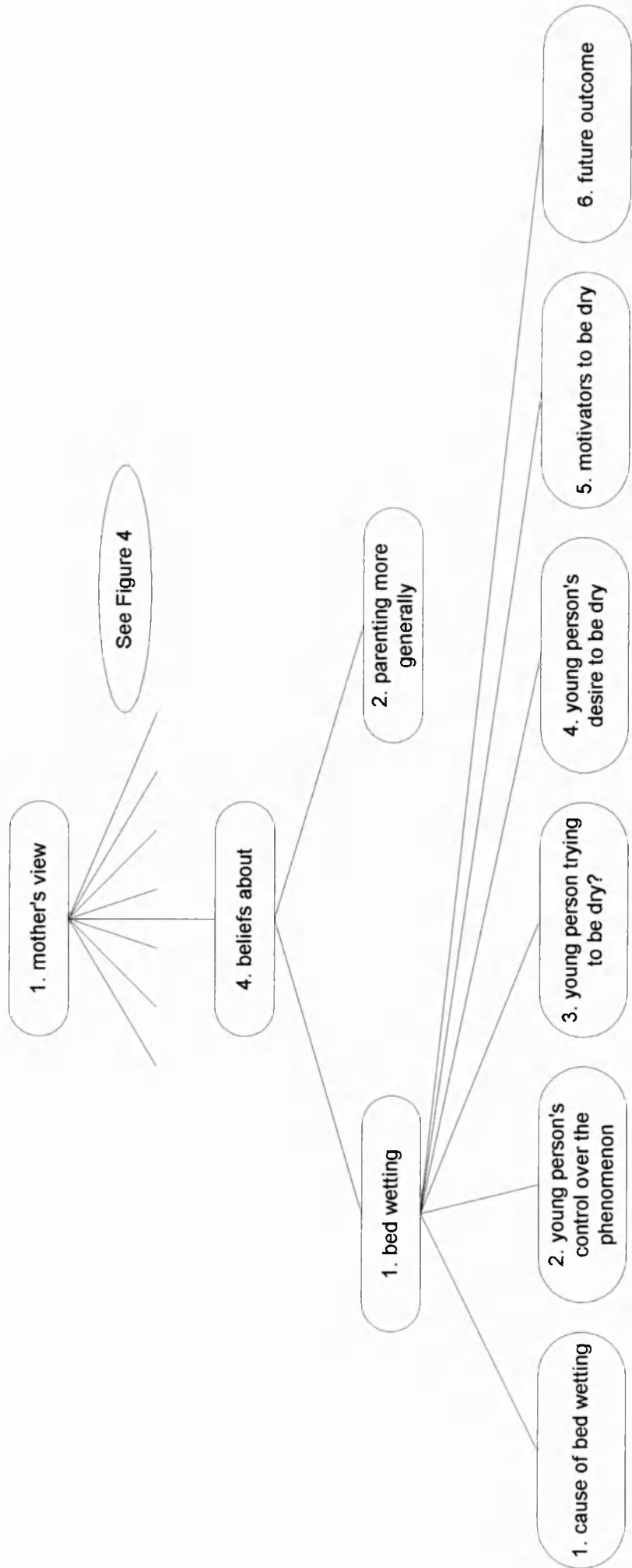
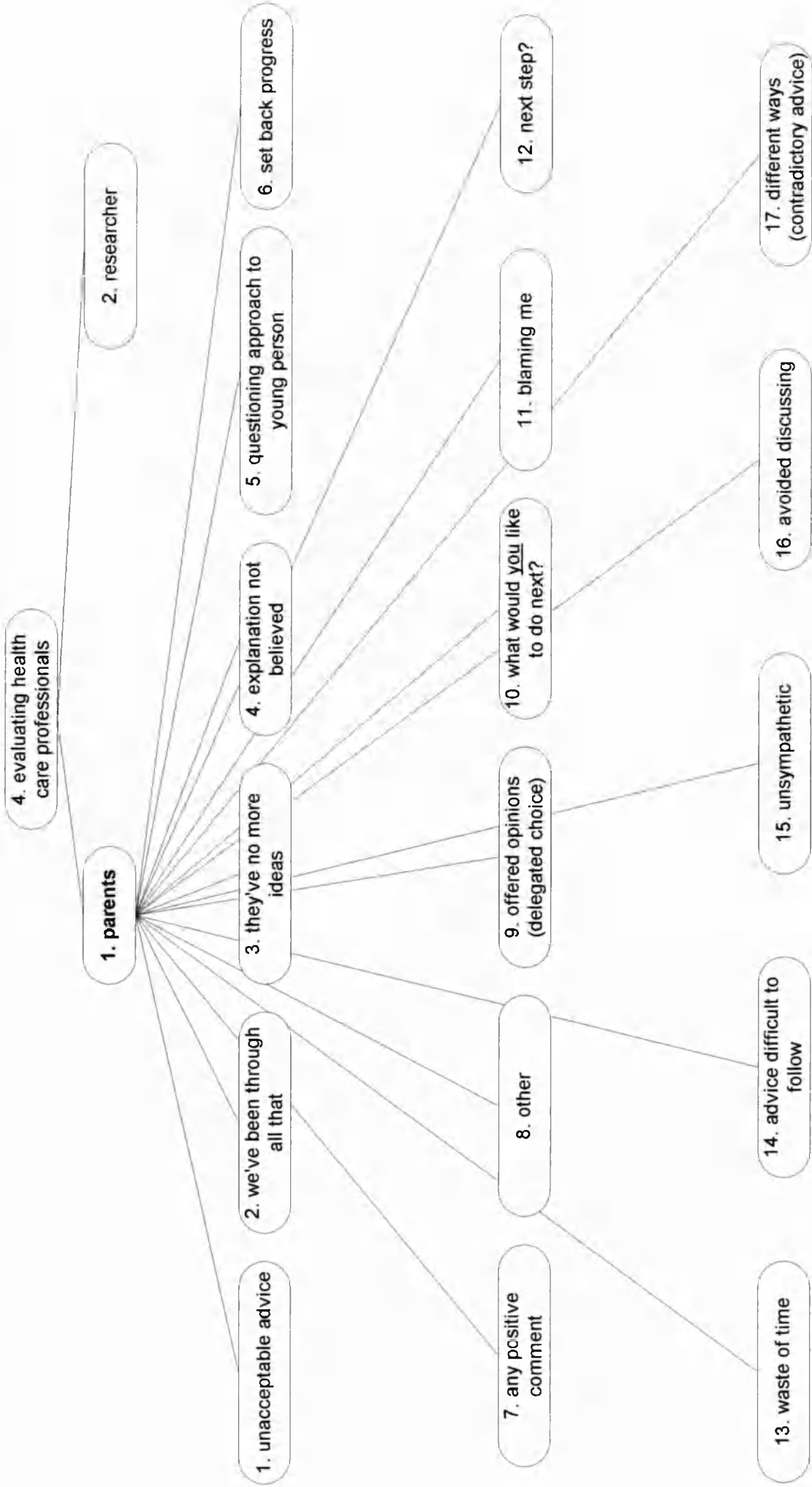


Figure 8 shows how the participant's own words (or a shorthand version of those words) could be used to label a category. This is called *in vivo* coding. Simply attaching names to the parents' spontaneous comments about health care professionals, during the earliest open coding, helped to ensure that this topic was not lost sight of.

The first eight nodes were identified during the first phase of open coding and collected together. Instances which did not seem to fall into any of the first seven categories were put into a miscellaneous category called "other". When the transcripts were re-coded more systematically other topics consistently emerged and new nodes were added.

The major indexing trees became the source of a "thick description" (Richards and Richards, 1994a) of families' experiences of bed wetting, as described in Chapter 5. While the principal indexing tree nodes highlighted the broad issues, attention to the details within each tree helped to ensure a balance when writing descriptive accounts. For example, reference to the tree illustrated in Figure 8 was helpful when writing Section 5.6.2 on parents' evaluation of health care professionals, helping to ensure that no one category was over-represented.

FIGURE 8 Indexing system for parent's evaluation of health care professionals, illustrating *in vivo* coding



3.9.4 Constructing and testing a grounded theory

The data handling tasks associated with theory development are complex. Theory testing is an integral part of theory construction, not a subsequent stage (Figure 3). In the present study the use of NUD•IST paved the way for the development of an integrated theory. Other researchers such as Dowd (1991) and Morse (1991d) have also found a computer programme to be of assistance in the development of a grounded theory. However the final integration of concepts was facilitated by the use of a coding paradigm, called axial coding (Strauss and Corbin, 1990).

Axial coding

Axial coding is a set of procedures whereby data are put back together in a new way, after open coding, by making connections between categories. This is achieved by using a coding paradigm involving: causal conditions (conditions which give rise to a phenomenon); the phenomenon or central idea; aspects of the context in which the phenomenon is embedded; intervening conditions; action/interactional strategies; and the consequences or outcomes of action and interaction, as illustrated in Figure 28 (Section 6.6.1) and Tables 16 and 17 (Sections 6.3.2 and 6.4.2).

The linking and development of categories takes place with the help of the basic analytical procedures used from the very outset of open coding such as asking questions about: what is going on, when and why, and making comparisons of instances of the phenomenon to gain an understanding of the conditions in which events take place.

Strauss and Corbin (1990) describe the process of axial coding as quite complex because the analysis involves performing four distinct analytic steps almost simultaneously. These are:

- (a) the hypothetical linking of concepts
- (b) the verification of the hypotheses against data
- (c) the continued search for the properties of the concepts and their dimensions, and
- (d) an exploration of the variation in expression of the phenomenon.

This involves moving back and forth between inductive and deductive thinking.

The identification of the core concept

The identification of what was initially believed to be the core concept of "perceived helplessness" occurred in the earliest stages of open coding. It was used to code the second line of the first transcript of the first conversation with the first family to be enrolled into the study and it returned in many guises later on. However the central phenomenon around which all the other categories were integrated became apparent during the later stages of analysis and was found to be "perceived control", as described in Section 6.2.1. The final stages of theory generation are described in Section 6.2, which includes a conceptual model developed to explore the relationships between beliefs, feelings and behaviour.

3.10 Criteria for judging this study

3.10.0 Introduction

"The naturalistic inquirer soon becomes accustomed to hearing charges that naturalistic studies are undisciplined; that he or she is guilty of "sloppy" research, engaging in "merely subjective" observations, responding indiscriminately to the "loudest bangs or brightest lights". Rigor, it is asserted, is not the hallmark of naturalism. Is the naturalist inevitably defenceless against such charges? Worse, are they true?"

Lincoln and Guba (1985) pp.289-290

The conventional criteria of trustworthiness used in research driven by positivist assumptions, namely: internal and external validity, reliability and objectivity are inconsistent with the axioms of naturalistic inquiry and inappropriate yardsticks for judging qualitative research (Altheide and Johnson, 1994; Brink, 1987, 1991; Hinds et al, 1990; Kahn, 1993; Kirk and Miller, 1986; Kvale, 1989; Le Compte and Gietz, 1982; Lincoln and Guba, 1985; Silverman, 1993).

Alternative criteria are suggested for judging this study beginning with a brief review of criteria proposed by Guba (1981) and Lincoln and Guba (1985). The criteria for judging a naturalistic inquiry in which a grounded theory approach has been adopted are then discussed, from the perspective of the researchers who first articulated the approach (Glaser and Strauss, 1967; Glaser, 1978; Strauss, 1987) and researchers with a broader research perspective such as Becker, (1993). This section concludes with a brief discussion of the hazards of "legitimation mania" (Kvale, 1995 p.37) and suggests a more pragmatic approach to the concept of validity in social inquiry.

3.10.1 Criteria for judging a naturalistic inquiry

Lincoln and Guba (1985) proposed the following criteria for judging a naturalistic inquiry:

- credibility, as a substitute for internal validity
- transferability, as a substitute for external validity
- dependability, as a substitute for reliability, and
- confirmability, as a substitute for objectivity.

Credibility

The search for internal validity in the conventional sense is ontologically inappropriate in qualitative research based on the naturalistic paradigm because it implies an isomorphism between research outcomes and a single tangible reality onto which inquiry can converge (Section 3.2 and Table 1).

Lincoln and Guba (1985) proposed an alternative criterion, which they called credibility, to establish the truth value of a study.

They suggest that the probability that the findings of a naturalistic study will be found to be credible is enhanced by:

- prolonged engagement (allowing sufficient time with respondents to build trust, learn the culture and test for misinformation)
- letting respondents speak for themselves, and
- suspending judgement (putting tentative hypotheses on hold and being wary of premature closure).

Every effort was made to adhere to these principles during the data collection phase of this study (Section 3.7) and the danger of premature closure was guarded against (Sections 3.9 and 6.2). One limitation of the study, however, is that engagement with the families could not be said to have been prolonged as each family was usually visited on only three occasions. Within these occasions, however, the researcher endeavoured to give the participants as much time as they wanted. Several parents thanked the researcher for the time spent in conversation and expressed the concern that they

had talked for too long. The conversations lasted on average approximately 1½ hours but ranged from about 45 minutes to over 2 hours.

One way of demonstrating the credibility of the findings of a study is to go back to the participants to establish their "truth value". However it has been decided in the light of the study's findings not to do this for fear of jeopardising the client-clinician relationship. The researcher first intends to discuss the results of the study with the health care professionals who helped with the recruitment of families (Figure 1).

The findings of this study have already been judged to be congruent with the professional experience of one of the advisors to this study (a consultant urologist) who has experience of helping families with a bed wetting child over many years and the comments of other professionals, including health visitors, are being actively sought. A useful external check on all aspects of the inquiry process has been provided by debriefing sessions with supervisors which occurred at approximately two-monthly intervals throughout the study. This included a discussion of selected transcripts, memos and logic diagrams.

Transferability

In conventional scientific inquiry the purpose of randomised sampling from a given defined population is to make the criterion of external validity achievable. However for the naturalistic inquirer the very concept of external validity is inappropriate:

"The extent to which findings may be applicable elsewhere depends upon the *empirical* similarity of sending and receiving contexts...The particular 'mix' of mutually shaping influences may vary markedly from setting to setting...Value systems, especially contextual values, may be sharply at variance from site to site."

Lincoln and Guba (1985) p.41

Instead of external validity Lincoln and Guba (1985) suggest substituting the term transferability, which is a measure of the extent to which it is possible to establish similarity of context. Context is crucial in deciding whether or not a finding may also have meaning in some other context.

Dependability

To the positivist, reliability is often taken to be synonymous with stability, consistency, predictability, replicability and dependability. Reliability is seen as a pre-condition for validity and is usually tested for by replication, for example in test/re-test study designs. The concept of reliability in relation to naturalistic inquiry fails because it requires absolute stability and replicability neither of which is possible for a study based on emergent design (Section 3.3).

In answer to the question: "How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same or similar subjects in the same or similar context?" the answer is that there is no "one reality" and there is therefore no possibility of convergence onto it. In qualitative research reliability as a concept is therefore meaningless.

Lincoln and Guba (1985), Erlandson et al (1993) and Rodgers and Cowles (1993) recommend keeping a record of the research process to demonstrate the dependability of a study. Records kept in relation to this study include the original research proposal and ethics of research submission; the raw data (audio tapes of conversations, copies of transcripts and field notes); information relevant to the method of data analysis, and coding trees, memos and diagrams used to facilitate data analysis and theory construction in practice.

Confirmability

The usual criterion for objectivity is that multiple observers can agree on a phenomenon. An alternative is to use methods which render a study beyond contamination by human biases. This is the motivation, for example, behind conducting double-blind clinical trials. In the context of naturalistic inquiry the criterion of objectivity is patently inappropriate because the paradigm openly acknowledges investigator-respondent interaction and inquiry as value bound (Table 1). The outcomes of a naturalistic inquiry actually depend upon the nature and quality of the interaction between "the knower" and "the known", epitomised in negotiations about the meaning of data (Section 3.7.2).

3.10.2 Criteria for judging a grounded theory study

Not all naturalistic inquiry has as its purpose the generation of theory. This section outlines further criteria by which a grounded theory study can be judged.

In a review of common pitfalls in published grounded theory research, Becker (1993) concludes that many grounded theory studies are in fact merely descriptive studies lacking conceptual depth, in which the researchers have borrowed pieces of grounded theory method but have not adhered to its critical components:

"These studies addressed what was going on, but the underlying how and why were absent."

Becker (1993) p.254

In the final chapter of their book on grounded theory procedures and techniques Strauss and Corbin (1990) discuss the scientific canons, that is the research standards by which a grounded theory study should be judged. The reader of a grounded theory study is encouraged to ask a series of questions about the study:

1. Are concepts generated?
2. Are the concepts systematically related?
3. Are there many conceptual linkages and are the categories well developed? Do they have conceptual density?
4. Is much variation built into the theory?
5. Are the broader conditions that affect the phenomenon under study built into its explanation?
6. Has process been taken into account?
7. Do the theoretical findings seem significant and to what extent?

These criteria are guidelines against which the theory described in Chapters 6 and 7 should be judged. Knowledge of these criteria helped the researcher to gain an understanding of the requisite properties of a grounded theory.

Strauss and Corbin (1990) suggest that the final test of the applicability of a theory to a phenomenon is control, that is the theory should suggest ways of guiding action and have implications for

practice. It is argued in Chapter 7 that the theory developed from the data of this study could have far reaching implications for both service organisation and service delivery.

3.10.3 Towards a more pragmatic concept of validity

In conclusion, in an article entitled "The social construction of validity" Kvale (1995) describes three approaches to validity which are not incompatible with the criteria described above but where there is perhaps a change of emphasis towards a more pragmatic approach. In the first approach, validity is regarded as an expression of the craftsmanship with which a study has been undertaken. The second involves testing the validity of knowledge claims in a dialogue with the subjects of the study and the scientific community. In the third approach justification of knowledge is replaced by application, that is with a pragmatic concept of validity.

Kvale (1995, p.37) warns of the dangers of a "legitimation mania" which he suggests leads to "validity corrosion". He suggests that the ultimate criterion whereby a study should be judged is that its findings are intrinsically convincing to the reader as "true":

"The quality of the craftsmanship results in products with knowledge claims that are so powerful and convincing in their own right that they carry the validation with them, such as a strong piece of art."
Kvale (1995) p.37-38

3.11 Summary

The aim of this study, as initially envisaged, was to explore the nature and experience of bed wetting from the perspective of young people who wet the bed, and that of their parents and siblings. A review of the literature suggested that there was still much to be learned about how families manage a young person's bed wetting in the context of every day family life. A qualitative, inductive approach was used which allowed the study's participants to explain in their own words and in other ways what the problem of bed wetting meant to them. Underlying the approach taken was the assumption that there could be concepts pertaining to the phenomenon of bed wetting that had yet to be discovered, or at least articulated in a coherent way.

Nineteen families and 20 young people aged 4 to 17 years, living in some of the most deprived as well as the most affluent localities in the study area, took part. The principal method of data gathering was in depth interviewing. The interviews were usually conducted over a period of two to three months for each family. This author's role as "researcher" rather than "nurse" was readily accepted by the families.

In depth interviewing of children and adolescents can be challenging. In recognition of the limits imposed by the children's cognitive, social and linguistic skills and in anticipation that some young people might be too ashamed about their lack of night time bladder control to be able to speak freely about it with a stranger, the young people were encouraged to express their feelings through drawings and with the aid of "faces-feelings" cards. These methods proved helpful in facilitating communication and the results were illuminating.

In addition to the in depth interviews with families, three supplementary methods of data collection were incorporated into the study's design for specific purposes. These were: a urinary symptom questionnaire, completed by the family before the researcher's first visit; diaries, in which the young person and his or her principal carer recorded events over a one month period as they actually happened, and a checklist of methods used by families in the past to encourage the young person's bed wetting to stop, completed by the researcher in consultation with the family at the conclusion of the last visit. By combining both qualitative and quantitative approaches and methods in a fully integrated way a clearer understanding of the totality of the meaning of bed wetting from the family's perspective has been gained than could have been achieved using one approach alone.

Analysis of the interview transcripts was facilitated by NUD•IST Power Version 3.0 computer software. With the aid of memos, logic diagrams and a coding paradigm (axial coding) the relationships between emergent concepts were identified and tested and a grounded theory developed around the core concept of "perceived control", which often manifested as "perceived helplessness". As is described in the Chapters 4 to 6, data analysis rapidly took the emphasis of the study beyond a descriptive understanding of the meaning of the experience of bed wetting from the perspective of individual family members, towards a new understanding of the processes going on within families and the conceptualisation of the family as a unique, multi-generational social system.

CHAPTER 4: AN INTRODUCTION TO THE FAMILIES

4.0 Introduction

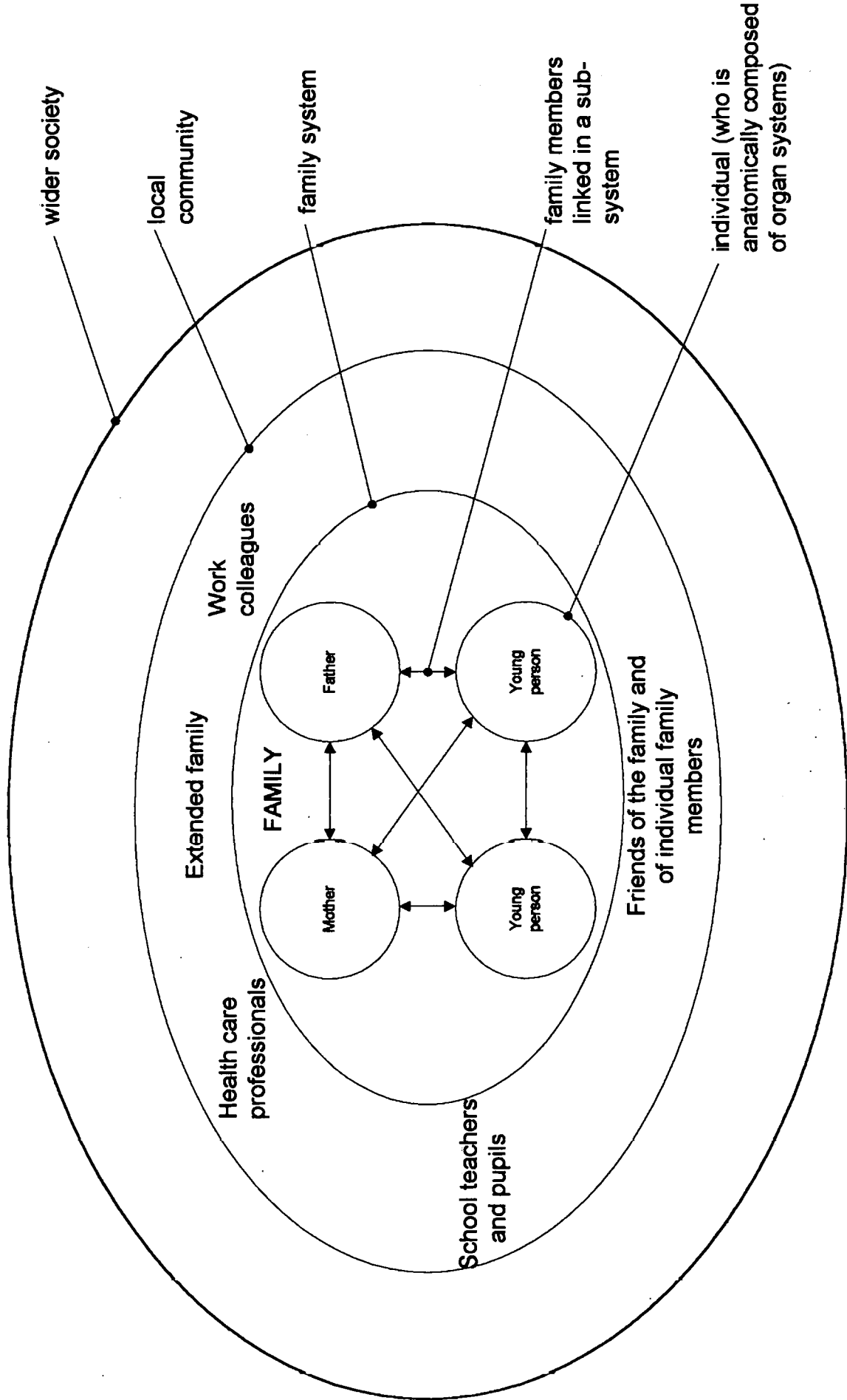
This section serves as an introduction to Chapter 4 and as a brief introduction to a conceptualisation of the family which is relevant to this chapter and to the chapters which follow.

In this study the family is seen both as the context in which a young person's bed wetting is managed and as a unit of interest in its own right. The focus of interest and the units of data collection and data analysis therefore encompass both individuals within the family and the family as a whole social unit, which in turn is seen as being embedded within a local community, set in a wider society (Figure 9).

This conceptualisation of the family was arrived at empirically but it is congruent with the axioms of the naturalist paradigm (Table 1), which provided the assumptions underpinning the methods used in this study and with the views of many family systems theorists.

As described in Section 2.3.2, there are many perspectives on the family among family systems theorists. Some, such as Bronfenbrenner (1986), take an ecological perspective, choosing to focus on the family within the context of the wider social systems of community and society. Other researchers, such as Hinde (1989), are more concerned with the nature and dynamics of interpersonal relationships within the family. In the present study the focus has been on the conditions affecting the action and interaction of family members and the consequences of these actions for the individuals involved and the family as a social unit. Some of the conditions identified have been at the ecological level and some at the individual level. The processes studied have for the most part been at the relational and interactional level, that is between members of a family living within the same household.

FIGURE 9 The conceptualisation of the family as a system, embedded within systems and composed of subsystems



Up until now the phenomenon of bed wetting has received most attention from researchers at the individual, pathophysiological, organ system level, that is at the level of bladder function (Figure 9 and Section 2.2.3). In the few studies where a more family oriented approach has been taken, the research has been conducted at the level of the mother-child sub-system, based on a unidirectional conceptualisation of the nature of the parent-child relationship (Section 2.4). In this study, by focusing on the family as a social system, a new perspective has been taken to understanding a common condition of childhood.

The aim has been to take a holistic approach to understanding the interaction of a multiplicity of variables on many system levels. While the focus of this study is predominantly on the level of the family (Figure 9), there are many hints that society's view of bed wetting and the attitude of extended family, friends, and health care professionals in the local community, have an impact on the family's experience of bed wetting, as does the nature of the young person's urinary symptoms. Failure to acknowledge the actual or potential impact of influences at these system levels on the family's experience of bed wetting would be both parochial and short-sighted.

It may be that the pathophysiologicals will find one unifying factor which explains the diversity of individual's experience of bed wetting and leads to the development of more consistently effective interventions (Section 2.2.3). Meanwhile, nurses may have the greatest opportunity for bringing about therapeutic change at the level of the family. This is, in itself, ample justification for the decision taken by the researcher who is a nurse, to study bed wetting from the family's perspective.

This chapter sets the scene for the chapters that follow by summarising certain contextual data at the local community, family and individual levels. Data about where the families live is summarised in Section 4.1. Household composition and the family's history of bed wetting are described in Section 4.2. The young people's day and night time urinary symptoms are summarised in Section 4.3.

The data presented in Chapter 4 are shown to be important for a holistic understanding of how families manage the practical day to day consequences of bed wetting and its wider social consequences, as described in Chapter 5. They are also shown to be integral to the theory described in Chapter 6.

4.1 The study area

This study was conducted in Stirling District, within the area of central Scotland served by Forth Valley Health Board.

The 1991 census revealed that only 0.7% of the total population of Forth Valley was of non-white ethnic origin, mostly from the Indian sub-continent and China. No families of non-white ethnic origin were formally enrolled into this study. Although one Chinese family was identified the family did not wish to take part.

The sample of 19 families was drawn from 11 GP practices. Four of the families live in a rural ward in West Stirlingshire. The other 15 families live within five miles of Stirling town centre.

The majority of the families' GPs are in the local GP Research Group. This group was initially selected and approached as a potential source of families because it included GP practices known to serve communities of considerable socio-economic diversity, from amongst the most affluent to the least affluent in the area (Section 3.6.1).

In Forth Valley there are neither the concentrations of deprivation nor of male unemployment that are to be found in other areas of Scotland such as Greater Glasgow. Male unemployment in Forth Valley was 11.9% in 1991, (approximately mid way between Greater Glasgow at 20.6% and the Shetland Islands at 5.6%) ranging from 4 - 32% locally by electoral ward.

Analysis of census-based deprivation indices for the district council electoral wards in which the families lived, which was undertaken after data collection was completed, confirmed the researcher's local knowledge that the families had indeed come from a wide spectrum of communities, from the relatively affluent to amongst the most deprived in the area. Six of the 19 families were drawn from three of the five wards assessed as having the greatest deprivation in the whole of Forth Valley. By contrast three of the 19 families came from two of the five most affluent wards.

4.2 The families

Family composition

Each family included a young person known locally to the health visitor to wet the bed and his or her natural mother. In one family the bed wetters were twins.

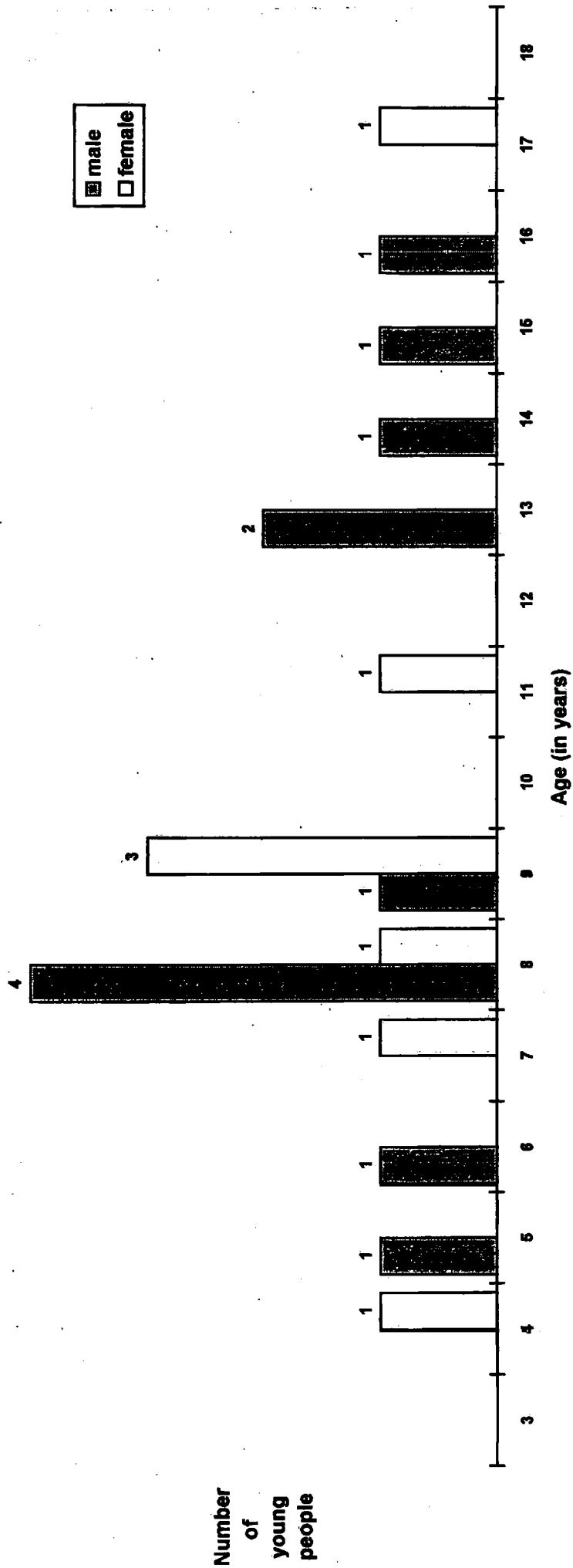
The 20 young people enrolled into this study ranged in age from 4 to 17 years with a mean age of ten. There were twelve males and eight females (Figure 10). All the young people were still attending school, the youngest was attending nursery school. With one exception, the cause of the young person's bed wetting was not known. Their day and night time urinary symptoms are described in Section 4.3.

All the young people in this study who wet the bed were living in families with at least one brother or sister. Fifteen (75%) had a younger brother or sister and 13 (65%) of them had a younger sibling who was dry at night (Section 5.3.1). In two families a younger child was discovered to be wetting the bed as well on three to four nights per week. These children were not known to the family's health visitor.

Three families (16%) were headed by a lone parent who was separated or divorced from the young person's natural father. The remaining households included the young person's natural father, a stepfather, or the mother's current male partner. Table 5 shows the marital status of the mothers at the time of the study and the number of times that the families had been re-ordered.

Re-ordering refers to the number of times that the parental composition of the household has changed within the young person's lifetime. Zero re-ordering means that the same parents had been present in the household since the child was born. In this study nine of the families (47%) had not been re-ordered.

FIGURE 10 Age and gender of the 20 young people taking part in the study (mean age 10 years)



**TABLE 5 The relationship of the parents living within the household,
and the number of times that the families had been re-ordered**

| <u>Parents within the household</u> | <u>Marital status of mother</u> | <u>Number of families</u> | <u>Number of times family re-ordered</u> (see Section 4.2) |
|---|-------------------------------------|-------------------------------|---|
| natural mother + natural father | married | 9 | 0 |
| natural mother + natural father | unmarried | 1 | 1 ¹ |
| natural mother only | separated/ divorced | 3 ² | 1 |
| natural mother + stepfather | divorced and re-married | 3 | 2 |
| natural mother + stepfather | widowed and re-married | 1 | 2 |
| natural mother + male partner (not natural father) | divorced | 2 | 2 |
| Total number of families | | 19 ³ | |

Notes

¹ mother lived with her parents for first 2 years of young person's life, then moved to live with young person's natural father, where she has remained.

² includes one family with twins

³ with a total of 20 children enrolled into the study

There were two types of one re-ordering, one where the natural father had come to share the residence with the mother and her son and one where the natural father had left the household, leaving the mother alone with her children. Four of the families (21%) had been re-ordered once.

In six of the families (32%) there had been two re-orderings. In these cases the natural father had left the household (through divorce or death) to be replaced by a stepfather or the mother's male partner.

In all, over half the young people in this study had experienced family re-organisation. The literature suggests that family re-organisation associated with divorce and re-marriage has become an increasingly common experience in the lives of parents and children (Hetherington, 1992). It is estimated that half of the couples married after 1970 will eventually divorce. Almost 50% of all children are expected to experience the divorce of their parents and to spend an average of 5 years in a single parent household; 72% of women and 80% of men re-marry (Glick, 1989).

In this study four of the young people currently had two father figures in their lives, their natural father with whom they stayed on occasions and a stepfather or the mother's male partner with whom they lived for the rest of the time. Four other young people no longer saw their natural father: in one case the father had died; in another case the young person did not wish to see her father; in the third case the natural father was in prison because he had abused the child, and in the fourth case the mother had obtained a Court Order denying the natural father access to the child. In two cases it was not known whether the young person was seeing the natural father.

There is growing evidence that divorce and re-marriage pose adaptive challenges to family members and involve alterations in family functioning; however, the short and long term effects of family transitions are far from clear cut (Allison and Furstenberg, 1989; Burghes, 1994; Guidubaldi, 1988; Hetherington et al, 1985; Zill, 1988; Zimiles and Lee, 1991; Cockett and Tripp, 1994).

In the present study one lone mother was finding it particularly difficult to cope with caring for her four children and described her relationship with her bed wetting daughter as poor. However the other two lone mothers and the six mothers who had re-married or had entered into a relationship

with a new male partner appeared to have found a new stability in their lives and five of them described their relationships with their children as good.

For two of the families in this study, which comprised both of the young person's natural parents, tension between the parents was reported by the mothers to be high and both mothers reported behavioural problems in their children. Many family theorists view the quality of the marital relationship and the couple's satisfaction with it as having all-important effects on other family relationships (Amato, 1986a; Belsky et al, 1991; Cummings et al, 1981; Denham and Couchard, 1991; Emery and O'Leary, 1984; Grych and Fincham, 1990).

The effect of the young person's bed wetting on relationships within the family is discussed in Section 5.4.1. One father was said by the mother to have threatened to leave the family because of it. It is not, however, possible to say whether bed wetting merely exacerbates problems between family members where relationships are already poor or whether the bed wetting is a primary cause of the problem.

The difficulties that family researchers have had in deciding what constitutes a "family" are described in Section 2.3.1. In the present study there were no instances of grandparents or other relatives or friends sharing the family home at the time when the data were being collected.

Parents' current employment

The nature of the employment of the parents currently living within the household is summarised in Table 6. The ways in which some parents' employment affected their involvement in the day to day management of the practicalities arising from the young person's bed wetting are described in Sections 5.1 and 5.2.

TABLE 6 Occupations of the parents currently living within the household

A. FATHERS' EMPLOYMENT

| <u>Occupation</u> | <u>Number of fathers¹</u> |
|---|--------------------------------------|
| Self employed steel importer | 1 |
| Self employed forestry manager | 1 |
| Self employed building developer | 1 |
| Travel agent, employee | 1 |
| Electrician | 1 |
| Self employed garage mechanic | 1 |
| Factory worker, manufacturing bottle tops | 1 |
| Bricklayer | 1 |
| University porter | 1 |
| Labourer, landscape gardening | 1 |
| Labourer, tarring roads | 1 |
| Unemployed | 2 |
| Not known | 3 |

B. MOTHERS' EMPLOYMENT

| <u>Occupation</u> | <u>Number of mothers</u> |
|--------------------------------------|--------------------------|
| Full-time housewife | 11 |
| Full-time undergraduate student | 1 |
| Part-time accountant | 1 |
| Part-time overnight garage attendant | 1 |
| Part-time cleaner | 5 |

Note:

¹ the term "father" is taken to mean the mother's adult male partner, currently living within the household. In 10 cases this was the young person's natural father, in 4 cases this was the young person's stepfather and in 2 cases the father figure in the household was not related to the young person by marriage or adoption (Appendix XIII)

Parents' personal history of bed wetting

It was discovered in conversation that six mothers had themselves been bed wetters. Four mothers who had not wet the bed themselves had had a bed wetting sibling and had had some responsibility for their sibling's care (Section 5.2.3). The natural fathers of four of the young people were said by their wives to have wet the bed (Appendix XIII).

There is evidence to suggest that there is a genetic component to the aetiology of bed wetting (Eiberg et al, 1995). Bakwin (1973) found that where both parents had been bed wetters 77% of their children were bed wetters, and if one of the parents had wet the bed 44% of their children experienced the problem. In Bakwin's study where neither of the parents had been a bed wetter, only 15% of their children were affected.

In the present study there was found to be a strong relationship between the nature of parents' previous experiences of bed wetting and their feelings, attitudes, and behaviour towards their own bed wetting child (Chapters 5 and 6).

Summary of contextual data relating to each family in the study

Contextual data relating to each family enrolled into this study is summarised in Appendix XIII. Pseudonyms are used for the young people. Appendix XIII gives the young people's age, the relationship of the parents currently living within the household, the number of times that the family had been re-ordered in the young person's lifetime, the relative deprivation of the electoral wards where the family live (Section 4.1), and the parents' experience of bed wetting, so far as this is known.

4.3 The night and day time urinary symptoms of the young people who wet the bed

4.3.0 Introduction

In this section the young people's night and day time urinary symptoms are described, based on an analysis of data from the urinary symptom questionnaires (Appendix I) completed by the young people and their parents before the researcher's first visit and an analysis of the conversations with families.

Of the 20 young people recruited to the study the cause of the bed wetting is only known with certainty in one case. Michael (age 8) has congenital bladder neck obstruction and only one, partially functioning kidney. He is in chronic renal failure and his symptoms include polyuria, which is the production of large volumes of dilute urine. The inclusion of Michael has proved a valuable case for comparison with the majority of cases where the cause of the bed wetting has not been identified (Chapters 5 and 6).

The section begins with a discussion of the frequency of the young people's bed wetting expressed as affected nights per week (Section 4.3.1), the primary or secondary nature of the bed wetting is discussed in Section 4.3.2 and the presence or absence of day time urinary symptoms is discussed in Section 4.3.3.

4.3.1 The frequency of bed wetting

The frequency of the young people's bed wetting, expressed as wet nights per week, is given in Table 7. Four (20%) of the young people were said to be wetting the bed on one night per week or less. Five (25%) were wetting the bed 2-4 nights per week and 11 (55%) were wetting the bed 5-7 nights per week. These findings are broadly similar to the findings of several surveys of the frequency of bed wetting in young people (Section 2.2.2). Devlin's (1991) survey of the parents of 1806 school children aged 4 to 14 years in Co. Kildare, Ireland, is nearest in age range to the range of ages of the young people in this study. Devlin found that 33% of these young people wet the bed once a month and less than once a week, 11% wet the bed once a week, 25% wet 2-4 nights a week, and 31% wet the bed on 5-7 nights a week. In the present study a somewhat higher percentage of young people (55%) were wetting the bed 5-7 nights per week.

A dimension of bed wetting, that neither the urinary symptom questionnaire (Appendix I) nor epidemiological surveys highlight, is the way in which the frequency of bed wetting can fluctuate widely for some individuals over time. The fluctuating nature of the frequency of bed wetting became apparent during conversations with families. For many young people the number of wet nights per week was said to have reduced, at first, with treatment but in most cases the young person's progress had not been maintained.

TABLE 7 Frequency of bed wetting (nights per week)^a

| Nights per week | Male | Female | Total | % of total |
|--------------------|------|--------|-------|------------|
| 7 | 3 | 4 | 7 | 35 |
| 6 | 2 | 1 | 3 | 15 |
| 5 | - | 1 | 1 | 5 |
| 4 | - | 1 | 1 | 5 |
| 3 | 3 | - | 3 | 15 |
| 2 | 1 | - | 1 | 5 |
| 1 or less | 3 | 1 | 4 | 20 |

Note: ^a source of data is urinary symptom questionnaire

In some cases the parents had their own "theory" to account for setbacks. Some mothers associated the increase in the number of wet nights with events occurring within the family at the time (Section 6.3.1). In most cases, however, both young people and their parents were puzzled when progress was not maintained.

It became apparent that four inter-related aspects of the frequency of bed wetting affected individuals' feelings about it, namely:

- the proportion of "wet" nights in the week (constancy)
- whether the frequency of dry nights was increasing, static or decreasing (presence or absence of progress)
- the extent to which the frequency of bed wetting and any changes in its frequency could be accounted for (predictability)
- the individual's perception of his/her ability to influence progress in a positive way (controllability).

Parents' and young people's beliefs about the causes of bed wetting and their control over it are discussed in Sections 6.3 and 6.4. The constancy of some young people's bed wetting, its unpredictability and uncontrollability had caused many young people and their parents to feel helpless and despairing at some point and for some individuals these were the predominant feelings at the time of the study (Section 6.3.2 and 6.4.2).

4.3.2 Primary and secondary bed wetting

Norgaard (1991) estimates that 10-15% of bed wetters are secondary bed wetters (Section 2.2.1). Three boys of the 19 young people in the present study, (16%), where the cause of the bed wetting was not known, were initially classified as secondary bed wetters (Table 8) using Hjälmås (1992, p.5) definition of secondary childhood incontinence:

"... a child who has been dry for a period of at least six months and then starts to wet again".

TABLE 8 Frequency of primary and secondary bed wetting^a

| | Male | Female | Total | % of total |
|--|------|--------|-------|------------|
| Primary bed wetting | | | | |
| a. never totally dry at night | 7 | 4 | 11 | 55 |
| b. reliably dry at night but for less than six months | 1 | 3 | 4 | 20 |
| c. not known if ever dry at night | - | 1 | 1 | 5 |
| Secondary bed wetting | 3 | - | 3 | 15 |
| Cause known (congenital bladder neck obstruction, only one partially functioning kidney and chronic renal failure) | 1 | - | 1 | 5 |

Note: ^a sources of data are urinary symptom questionnaire and conversations with parents

These three boys were said by their parents to have been reliably dry for between one and two years before recommencing bed wetting at the ages of 3½ - 4 years. According to Fergusson et al's (1990) definition (Section 2.2.1) these boys would not have been classified as secondary bed wetters at all, although they had been reliably dry for so long, as they had re-started bed wetting before the age of 5. The failure to classify children who have been dry for 1-2 years as secondary bed wetters could have implications for randomised controlled trials conducted in young people who are all supposedly primary bed wetters.

The mothers clearly remembered the circumstances in which the bed wetting had recommenced. In the case of the twins, Stephen and John (age 8) the bed wetting had started shortly after the parents had separated and the twins had entered a homeless unit with their mother. Stephen was said to have been particularly badly affected by the experience and at the time of this study, four years later, he was still wetting the bed 7 nights per week. John's bed wetting had considerably improved over the intervening years and by the time of the study he was only wetting the bed 3 nights per week.

The mother of Gary (age 5) linked the re-commencement of her son's bed wetting to the natural father coming to live in the family home. She said that she and her son had been happily living with her parents before that time and Gary had been out of nappies and reliably dry for a year. The onset of the secondary incontinence was also said to have been very sudden.

An observation which emerged through conversations with parents in the study, but not from the urinary symptom questionnaire (which asked whether the young person had ever had a period of at least 6 months when they had been dry every night), was that four of the "primary" enuretics had been out of nappies at night and had been reliably dry for several months, but less than six months, when the bed wetting had suddenly recommenced (Table 8):

"Mrs L: She came out o' nappies and for the first few weeks she never wet, but then all of a sudden she started again. She was about 2½."

Mother of Lisa (age 4) 17228/18 p.3

Lisa's father also remembered his daughter as having been "trained" at night at one point. The parents were vague about the family's circumstances at the time when the bed wetting re-started, but shortly afterwards the father went to live with his mother for six months, although he visited the

children in the evenings. Lisa was still wetting the bed for 7 nights per week when she entered this study, at the age of 4.

In two other cases the young person was quite clearly described as being emotionally upset when the bed wetting recommenced. In one case the young person's father had died. In another case the circumstances surrounding the re-commencement of the young person's bed wetting were said to have been dramatic:

"Mrs S: It was when she was 2½ that she had this - like a nervous breakdown ... before that she was completely potty trained - both day and night - no problems - we were off nappies - nothing. And then all of a sudden, I don't know what happened, she just changed. It was like an overnight thing. She started wetting the bed, she started wetting herself, and her bowels opened as well - and she started doing the toilet up the carpet, and she'd be walking and doing the toilet at the same time - and I just couldn't cope with this. Immediately of course she got on nappies. And that's the cycle ever since."

Mother of Sarah (age 11) 17222/37 p.1

Sarah was still wetting the bed 6 nights per week when she entered this study at the age of 11. In the interim she had had problems with anorexia, she was still being seen on an occasional basis by a clinical psychologist and her weight was being regularly monitored by the paediatrician at the local hospital. This mother felt that health care professionals blamed her for Sarah's problems (Section 5.6.2).

On hearing about this study a family friend told the researcher how one of her sons started wetting the bed again at the age of 2, after several months of being reliably dry at night, when his younger brother was born. She had been in hospital for two weeks with the new arrival and her husband had not been allowed to visit their 2 year old son, who was temporarily taken into a children's home. She said that it had taken many months of loving care to re-establish a close relationship with this child and to re-establish night time bladder control. This all took place 40 years ago at a time when the effects of maternal deprivation were only just beginning to be widely reported in the research literature.

There is not the space here to enter into a detailed discussion of the controversy surrounding the issue of whether bed wetting can be precipitated by psychological factors. Some health care professionals researching the pathophysiology of bed wetting (e.g. Djurhuus et al 1992) discount

psychological disturbance as a contributory factor. However, the research of others who have compared enuretic with non-enuretic children (e.g. Jarvelin et al, 1990, 1991; Larsen and Winther, 1980; and Oppel et al, 1968b) suggests that stressful life events, including divorce, parental separation, marital conflict or birth of a sibling can be precipitating factors, especially in children who have been late in acquiring primary bladder control. It has been suggested that this makes a child more susceptible to developing secondary enuresis when exposed to stressful life events (Fergusson et al, 1990). In this study some parents attributed the young person's bed wetting to the child's emotional response to a social problem between members of the family (Table 15, Section 6.3.1).

4.3.3 Day time urinary symptoms

Questions about day time urinary symptoms, including day wetting and urgency, were included in the urinary symptom questionnaire (Appendix I), to see whether the young person's lack of bladder control was confined to night time.

The prevalence of day wetting for the young people in the study was high at 75% but for 11 of these 15 young people the problem was said to be very occasional or occasional (Table 9). Seven of the young people in this study (3 boys and 4 girls) experienced a loss of day time bladder control which would be visible to others in that the leakage of urine was said to occur through to the outside of clothing (Table 9). Visible loss of day time bladder control is shown to have had significant social consequences for these young people (Section 5.3.2). Contrary to the findings of Hellstrom et al (1990), there did seem to be an association between day wetting and frequency of wet nights per week. The four young people who were reported as day wetting "very often", with the urine leaking visibly to the outside of their clothes, were also said to wet the bed seven nights per week (Table 9) and for three of the four young people, said to wet occasionally in the day time, the leakage was also "sometimes" or "usually" of the type which would be clearly visible to others. These seven young people had the double disadvantage of visible day as well as frequent night time problems with their bladder control which made the maintenance of secrecy impossible (Section 5.3). In contrast the five young people who had no day wetting problem only wet the bed three nights per week or less (Table 9).

TABLE 9 The usual frequency of bed wetting and the frequency and severity of day wetting^a

| | Age | Usual frequency of bed wetting (nights/week) | Frequency of occurrence of day wetting | | | | | Leakage of urine to outside of clothes ^b | | |
|----------|-----|--|--|-------------------|--------------|-------|------------|---|----|----|
| | | | Not at all | Very occasionally | Occasionally | Often | Very often | Yes Usually | No | NA |
| Carol | 17 | 7 | | | | | ✓ | ✓ | | |
| Anthony | 16 | 6 | | ✓ | | | | | ✓ | |
| Peter | 15 | 6 | | | ✓ | | | | ✓ | |
| Roger | 14 | ≤1 | | ✓ | | | | | ✓ | |
| Paul | 13 | 3 | ✓ | | | | | | | ✓ |
| Ian | 13 | ≤1 | ✓ | | | | | | | ✓ |
| Sarah | 11 | 6 | | ✓ | | | | | ✓ | |
| Jennifer | 9 | 4 | | ✓ | | | | | ✓ | |
| Alison | 9 | 7 | | | | | ✓ | ✓ | | |
| Tracy | 9 | 5 | | ✓ | | | | | ✓ | |
| William | 9 | 3 | | ✓ | | | | | ✓ | |
| Michelle | 8 | ≤1 | ✓ | | | | | | | ✓ |
| Simon | 8 | 2 | | ✓ | | | | | ✓ | |
| Stephen* | 8 | 7 | | | | | ✓ | ✓ | | |
| John* | 8 | 3 | ✓ | | | | | | | ✓ |
| Michael | 8 | 7 | | | ✓ | | | ✓ | | |
| Shelly | 7 | 7 | | | ✓ | | | | ✓ | |
| Martin | 6 | ≤1 | ✓ | | | | | | | ✓ |
| Gary | 5 | 7 | | | ✓ | | | ✓ | | |
| Lisa | 4 | 7 | | | | | ✓ | ✓ | | |

Notes: ^a a source of data is the urinary symptom questionnaire

^b none of the young people wore a pad or any other form of protection to absorb any leakage of urine

* twins

Through conversations with parents and the young people themselves, it transpired that seven of the young people had recently had a day wetting episode at school, and a further four had had problems with day wetting incidents at school in the past. A summary of the night and day time urinary data for each young person in this study is presented in Appendix XIV, in which the sources of the data are clearly indicated.

4.4 Summary

The families enrolled into this study have been drawn from some of the most deprived as well as the most affluent wards in the study area and include young people aged 4 to 17 years wetting the bed from seven nights per week to less than once a week. Half these young people had experienced family reorganisation. At the time of the study each family included the young person who wet the bed and his or her natural mother. In three families the mother was a lone parent, in six families the father was a step father. Ten families included the natural father.

The findings of this and other studies highlight that remarkably little is known about the natural history of the acquisition of nocturnal bladder control (Blackwell, 1992). The fundamental question remains unanswered: how many dry nights does the child need to achieve before it can be said that the physiological mechanisms required for bladder control are in place and capable of functioning reliably? The experiences of four of the sixteen families in this study, with a child originally classified as a "primary" bed wetter, suggest that there could be a "critical period" during which learning how to be dry at night can be undone, perhaps at times of stressful life events within the family. In the present study the four children who were reported by their mothers as having been reliably dry both day and night before the age of 2 to 2½ years, were aged 4, 6, 9 and 11 on entering the study. These young people were also amongst the most severely affected bed wetters.

The consequences of the young people's night and day time urinary symptoms for themselves and for their families are described in Chapters 5 and 6.

5.0 Introduction

This chapter is about the ways in which families experience a young person's bed wetting, within the context of every day family life and its social consequences for individual family members and for the family as a social unit. It seeks to answer the broad research questions posed at the beginning of this study (Section 3.1).

New insights are provided into the nature of bed wetting and the way it is experienced by families. It is shown that the consequences of bed wetting are rarely confined to night time and can affect key times of communal family activity (Section 5.1). New perspectives have been gained of the roles that different family members play in the day to day management of bed wetting, including the role of fathers and siblings (Section 5.2). Sections 5.3 and 5.4 illustrate the pervasiveness of the social consequences of bed wetting for everyone in the family. The strategies that parents devise for themselves to encourage the young person's bed wetting to stop are outlined in Section 5.5. Parents' and young people's evaluation of the help received from health care professionals and the nature of their experiences of methods commonly prescribed (Section 5.6) suggest many ways in which practice could be improved to meet the family's needs (Chapter 7).

This chapter is for the most part a descriptive account, however many of the themes and concepts described here form the building blocks of the theory developed in Chapters 6 and 7.

5.1 How do families experience the day to day practical consequences of bed wetting?

5.1.0 Introduction

In this section, the practical, day to day consequences of bed wetting are described, using data derived from the parents' diaries and from conversations with parents and the young people themselves. It focuses on the extent to which different family members were aware of and disturbed by the bed wetting and the times of day (or night) when the practical consequences of the bed wetting were being dealt with.

The night and day time urinary symptoms of the young people are described in Section 4.3. Some young people were found to be wetting the bed nearly every night while others were wetting once a week or less. This has obvious implications for the burden of care for parents and the pervasiveness of the practical consequences arising from the bed wetting for all the family.

The data show that the consequences of bed wetting are not confined to night time, indeed for most older children and their parents night time disturbance was rare (Section 5.1.1). For most families bed wetting was found to have its biggest practical impact in the mornings as family members were rushing to leave home for school or work (Section 5.1.2). Bed times also proved to be a time of tension in some families in anticipation of the young person wetting the bed (Section 5.1.3).

Within the families the issues were different for young people of different ages. While most parents expected to have to help younger children with tasks relating to personal hygiene and bed changing, the parents of adolescents were often particularly frustrated by the young person's reluctance to take responsibility for managing practical tasks which were deemed to be well within their capabilities.

5.1.1 Night time activities

Insights into night time activities relating to bed wetting were gained from three sources: the urinary symptom questionnaire (Appendix I); from conversations with family members and from the diaries kept by the young people and their parents (Appendices II and III) (Section 3.7.3).

While many of the young people may have had more than one complete micturition during the night, 13 (65%) were normally unaware of having wet the bed until they woke up in the morning, and in most cases their parents were also undisturbed through the night. Three young people (15%) awoke once during the night, and four (20%) of the younger children woke two or three times to a wet bed. The youngest children woke up in the night most often. However, during the month of the diary keeping, only four mothers were disturbed in the night because of a wet child. The majority of parents were rarely if ever disturbed (Appendix XV).

The notable exception to this was Michael's mother. According to her diary she was up on average twice a night to her son, who had only one, partially functioning kidney and suffered from polyuria

(an increased output of dilute urine) (Section 4.3.0). "In the night" meant after she herself had gone to bed and before she finally got up in the morning. She kept her diary faithfully, recording her feelings about a wide range of issues for her:

"MRS M: Fell asleep at 2.30 until 3.15 p.m. Find it hard to keep my eyes open some days."

Mother of Michael (age 8) Day 2 of diary

At the beginning of the diary keeping Michael's mother had wondered how she would feel about seeing everything written down. She had underestimated her involvement with Michael during the night, in the urinary symptom questionnaire (Appendix XV). This is her last diary entry:

"MRS M: Well, this is the last page of the diary. It has been quite strange writing this over the last few weeks ... I don't think much about being up every night. It is just a way of life. You have to work your life around it."

Her diary showed that she had changed Michael's nappy on average three times after he had gone to bed at night, ranging from twice to five times. Both Michael's parents had come to accept a situation which they believed could not be changed and which they knew was outwith Michael's control (Section 6.3.2).

Like his mother, Michael kept his diary meticulously. A page of his diary is given as Figure 11. His mother encouraged him to use the toilet whenever she found him wet but the diaries show that she was mostly unaware of how often he got up to the toilet by himself. According to his own diary this was, on average, four times per night. Other mothers were also unaware of the young person's night time activities.

The diary entries sometimes reflected parents' feelings of frustration about the bed wetting and described circumstances when disturbances relating to bed wetting could be problematic:

"MRS W: William wet when I got him up and I was annoyed because I've got myself so keyed up about my interview and I just wanted to flop into bed so I was quite abrupt with him, changed and dried him as quickly as poss. Was flustered this morning because he was wet again and I was already in a panic about the time but he had washed himself."

Mother of William (age 9) Day 6 of diary

FIGURE 11 A page from Michael's night time diary (age 8)

YOUNG PERSON'S NIGHT TIME DIARY

Note: N = nappy

This is your diary of wet and dry nights and how often you have to get up at night to go to the toilet. It is very quick and easy to fill in.

Please - put a B below the clock nearest the time you go to bed

- put a T below the clock nearest any time when you visit the toilet during the night

- put a W below the clock nearest any time when you wake up wet

- put a D below the clock nearest when you finally get up in the morning if you are dry, or a W below this clock if you are wet.

| | EVENING | | | | | NIGHT TIME | | | | | | | MORNING | | | | | |
|------------------|---------|-----|----------------|----------------|------|----------------|----------------|----------------|----------------|----------------|-----|-----|----------------|-----|-----|-----|------|--|
| | 6pm | 7pm | 8pm | 9pm | 10pm | 11pm | midnight | 1am | 2am | 3am | 4am | 5am | 6am | 7am | 8am | 9am | 10am | |
| MONDAY - Tue | | | | B | | T | | h ^w | h ^w | T | | | | BD | | | | |
| TUESDAY - WED | | | | B ^T | | | T | T | h ^w | | | | BD | | | | | |
| WEDNESDAY - Thur | | | | B ^T | | h ^w | | | E | | | | h ^w | | | | | |
| THURSDAY - FRI | | | | B ^T | | | h ^w | | | h ^w | T | T | T | EP | | | | |
| FRIDAY - SAT | | | h ^w | T | T | T | h ^w | | T | | T | | h ^w | T | D | | | |
| SATURDAY - SUN | | | | B ^T | | | h ^w | T | | T | | T | | BD | T | | | |
| SUNDAY - MON | | | | B ^T | | | | h ^w | | | | | h ^w | | | | | |

Completed by: Young person ☒ Young person with parent ☐ Other (please specify) ☐ 120

Few fathers were involved in the management of the practicalities arising from the young person's bed wetting (Section 5.2) but Paul's father was actively involved and he described similar circumstances when getting up in the night to his son was a task he could have done without:

"Mr P: The only time that's bothered me particularly has been when - you know - in particularly stressful times workwise, that when you know - once you're awake you're not going to get back to sleep again, and that can be - I had a spell of that 18 months ago, and that was annoying and frustrating at that stage but it didn't happen very often, so it didn't matter. But I was conscious of thinking: 'I hope to goodness it's not tonight!'"
Father of Paul (age 13) 156/28 p.12

These occasions tended to be memorable but for the majority of the parents, for most of the time, disturbances at night in relation to bed wetting were uncommon. This may in part account for parents' lack of tolerance of the disturbances associated with the use of bedside or body worn alarms (Section 5.6.1).

It has been found that the greatest impact of bed wetting for most families, in the practical sense, is not at night but in the mornings, as family members hurriedly prepare to leave the house for school or work, as is described below.

5.1.2 The morning rush for school

In many households with children it is quite normal for week days to start with a period of frenetic activity as children prepare to leave the house for school and many parents get ready to go to work. Younger children may need supervision with washing and dressing, there is breakfast to eat, perhaps packed lunches to prepare and pets to organise. A baby may need comforting, children may be clamouring for their sports kit, perhaps the parents quickly glance through the mail. A young person's activities in relation to managing the consequences of a wet bed take place in the context of behaviour which is quite normal for the young person's age (if irritating for parents!). Many mothers said that the "morning panic" was made worse on those mornings when the young person needed extra attention because they were wet:

"Moya: So what were mornings like?
"Mrs M: Terrible. Just this boy with the nappy on, sort of thing. He got washed in the bath - hair too, when he hadn't had a nappy on. It was extra work. They get a bath every night so it should only be hands and face in the morning."
Mother of Martin (age 6) 1517/18 p.2

Before taking Tryptizol Martin had been wetting the bed virtually every night and these morning experiences were normal for the family then.

The problem was compounded in families where a young person had wet someone else's bed as well:

"MRS L: She was wetting all the beds at night and you are up changing beds in the night and having to bath her brother before he went to school in the morning ... he was having to get up an hour early and he was getting up during his sleep. It was a shame."

Mother of Lisa (age 4) 1517/31 p.2

Wetting more than one bed in one night was not uncommon, being mentioned by the parents of six children. At the time of this study three families included two young people who wet the bed regularly. This compounded the work for the mothers even when one or both of the young people was largely self-caring.

Many of the 7 - 9 year olds were said by their mothers to require only minimum supervision, even when they were wet. In some households a routine had been established:

"MRS S: Well, it was just a matter of, if he was dry he would come down and tell me he was dry and if he was wet I would say to him, 'Just take the sheet off, take off your pyjamas and put them out for washing' and then I would put a dry sheet on his bed and either I put it on or he put it on. So that was it. That was all there was to it. Nobody got cross."

Mother of Simon (age 8) 15122/3 p.2

The younger children tended to need some help, especially with their personal hygiene, and this was not always forthcoming.

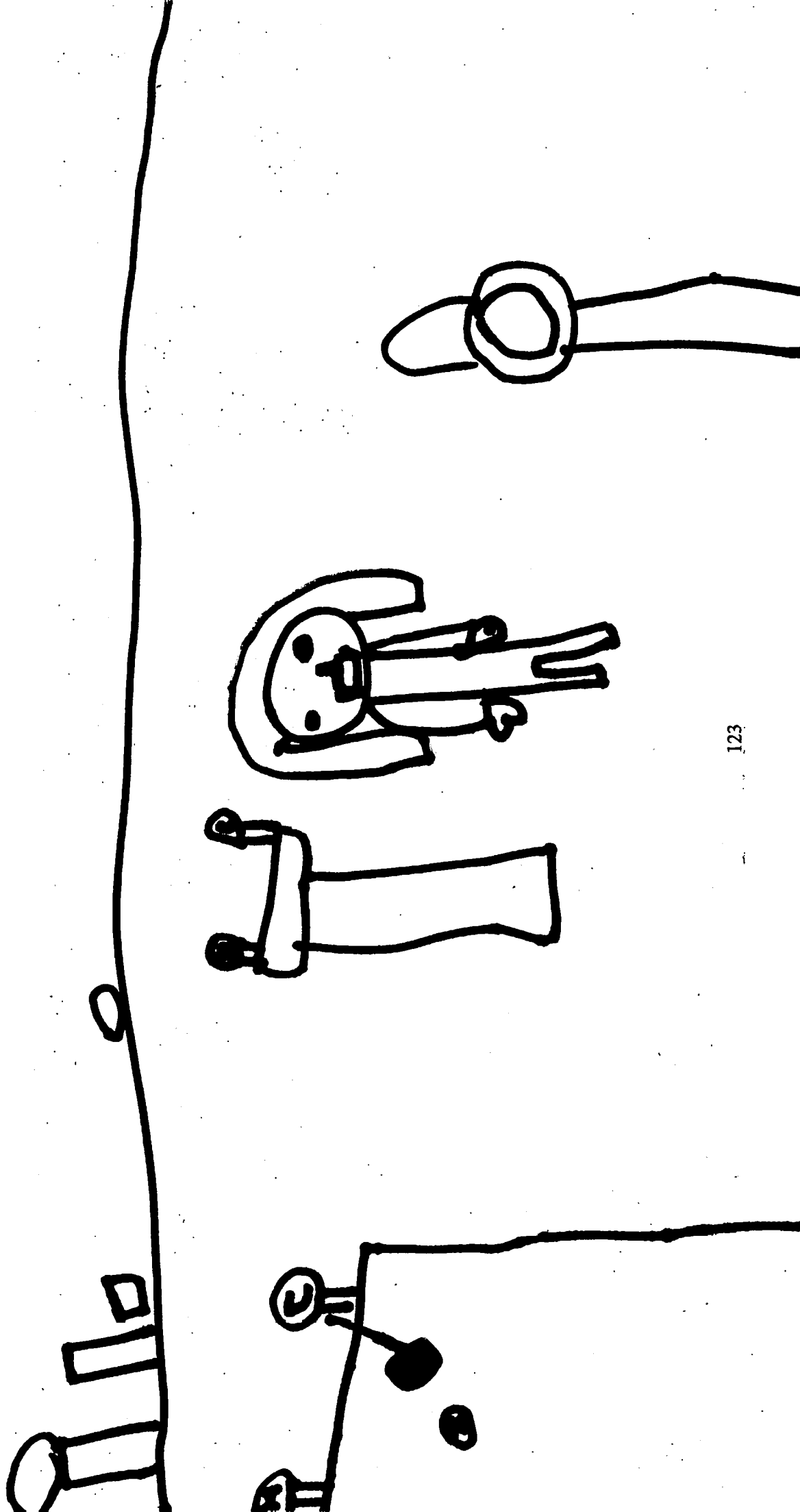
Shelly was at first teased by her brother and sister, and then by the children at school because she smelt of urine:

"MRS S: There were times when she went to school you could actually smell it on her sometimes. I started washing her but when she got older and that she started doing it herself and I made sure she was clean before she went to school. They don't bother her now."

Mother of Shelly (age 7) 15125/26 p.1

Shelly's mother was very relaxed about her daughter's bed wetting (Section 6.3.2) but Shelly was unhappy about it (Section 6.4.2). When asked to draw a picture of how she felt in the mornings when she woke up to find herself wet Shelly drew a picture of herself in the bathroom (Figure 12).

FIGURE 12 Shelly's drawing of herself on finding herself wet in the morning (age 7)



Shelly said that she was happy about the practicalities of managing a wet bed, such as changing the sheets and changing herself. Martin, Gary and Michelle felt much the same:

"MARTIN: I liked it, I took the sheets off and they went in the bin."

Martin (age 6) 3213/44 p.1

"MICHELLE: It's good - then I've not got the smell any more."

Michelle (age 8) 3213/6 p.2

One indication of the shame felt by young people about their lack of night time bladder control is that so many had at some time tried to hide the bed wetting from their parents. In some cases the young person was frightened to admit to it:

"Mrs L: At first it was a shame because sometimes I used to get crabbit (angry), there's no point in saying I didn't, during the night she was waking me up and I said, 'for God's sake Lisa, I've not got a tumble drier, it's broken. How am I going to get these done?' I maybe got crabbit to start with ... and she would maybe be feared to tell you or she'd hide her pants - it does not bother us now."

Mother of Lisa (age 4) 15117/30 p.6

Other children were said to have hidden wet night clothes when they had been offered a reward for achieving a certain number of dry nights (Section 5.5.2).

Talking with families about the management of the consequences of bed wetting from day to day sometimes revealed a great deal about the young person's self esteem or lack of it. In contrast to the majority, Carol and Tracy gave the impression of having given up trying to help themselves even in practical ways, expressing feelings of helplessness and hopelessness (Section 6.4.2). This manifested itself as apathy when it came to managing the practical consequences of the bed wetting. The parents of both Carol and Tracy were concerned about this:

"MRS T: But she doesn't even get up, she just lies there in it.

MOYA: What, in the urine?

MRS T: Aye, and when she soils ... And you've got to force her to go into a bath and everything. She just doesnae - ... With Laura (the other bed wetting child in the family, age 4) when she is wet, she gets up and takes it off and jumps into Kevin's bed, whereas with Tracy, she lies in it all night.

MOYA: And how does she manage in the morning? Does she wash herself, or do you have to supervise her?

MRS T: I've got to tell her or she wouldnae do anything, you know.... it just doesn't seem to get through to her."

Mother of Tracy (age 9) 15121/9, 17 & 18 p.1 & 2

Both Carol and Tracy seemed to be unhappy about life in general, as well as being unhappy about the bed wetting. Both seemed to be displaying some symptoms of clinical depression such as feelings of sadness, worthlessness and pessimism about the future, which may or may not have been related to the turbulent events in their earlier family life. Until recently it was widely assumed that children and adolescents rarely exhibit depression but recent research has shown that it is far more common than clinicians had thought (Hetherington & Park, 1993; Mussen et al, 1990). Seligman and Peterson (1986) describe one form of childhood depression which has as its basis repeated experiences of defeat over a prolonged period, with the young person having tried hard to solve problems and achieve personally meaningful goals without success. Mussen et al (1990) suggest that the majority of adolescent suicide attempts are a result of a long series of unsuccessful attempts to find alternative solutions to difficult problems, rather than being a momentary impulse. The inability to achieve dry nights after many years of trying could contribute to a young person's feelings of worthlessness (Section 6.4.2).

Returning to the morning rush for school, dealing with the young person's personal hygiene, where help or encouragement were needed, was assigned a higher priority than dealing with the wet sheets in most families, however, issues relating to the handling and laundering of the wet sheets emerged again and again as causes of irritation for some parents. The issue which caused a great deal of conflict in the families of some adolescents was who should remove the sheets. The tension surrounding this issue could carry forward through the day until the young person arrived home from school when the young person might find an angry mother and an unmade bed. These parents felt that the young person was old enough to take some responsibility for managing the practicalities and left the bed unchanged as a matter of principle:

"MRS P: And there's been times when I thought, no, I'm just going to leave the bed, and he'll come in 4 o'clock and he brings a friend home with him - 'Is my bed made, Mum?' and I say, 'No' - and of course I rush through, give them a glass of juice and make the bed, and cover it up for him. You know you don't want to embarrass them but you know if he was making an effort it might push him a bit just to - "

Mother of Peter (age 15) 51/3 p.1

In spite of her feelings of frustration Peter's mother was still concerned to protect her son from the embarrassment of discovery by others. Several mothers described their diversionary tactics as they removed the evidence of their child's bed wetting when the young person's friends called at the house.

The range of young people's feelings about the practical side of changing themselves and changing the sheets is shown in Table 10. Overall, the younger children seemed more biddable and more enthusiastic about removing the sheets than many of the older ones, who regarded it as a chore:

"Ian: It's boring. I had to do it every morning, like."

Ian (age 13) 3213/47 p.2

Perhaps many of the older children had become apathetic about managing the wet sheets because the problem had been going on for so long, but most were still very particular about their personal hygiene and were happy to distance themselves from the problem, leaving the house and their secret behind them in the rush for school.

With the help of a faces-feelings card eleven young people were asked how their mother felt about the practicalities. Carol and the twins, John and Stephen, said that their mother was as unhappy about it as they were:

"MOYA: And how does mummy feel about it?

JOHN: Grumpy.

MOYA: She feels grumpy about it too? Why does she feel grumpy about it?

JOHN: Because her machine has broken down.

MOYA: Oh dear me! You're laughing. Why are you laughing?

JOHN: Just because the way she goes in a horrible mood."

John (age 8) 3221/122 p.1

John did not seem to take his mother's anger personally but attributed it to the practical difficulties caused by the broken washing machine. He himself "hated" taking the sheets off. Perhaps the sheets reminded him of a problem that he would rather forget. Eight young people indicated that their mother was more concerned about the practicalities than they were (Table 10).

In summary, mornings could be a tense time for some young people when they had to face the consequences of the wet bed and the whole family could be affected in one way or another. Mothers with younger children, who needed most help with their personal hygiene, often had most to do in the practical sense. Siblings could be affected too, if they and their bed had been made wet and it could be that some received less attention in the morning when the mother was engaged elsewhere. Most fathers were not directly involved in the practicalities (Section 5.2.2) but they too may have been affected by a blocked bathroom, or a harassed wife.

TABLE 10 How the young people felt about the practical side of managing a wet bed (changing the sheets and changing themselves)
and their perception of their mother's feelings about it Note: a nights per week

| A G E | USUAL FREQUENCY OF BED WETTING ^a | YOUNG PERSON'S FEELINGS | | | | | | NOT ASKED | YOUNG PERSON'S PERCEPTION OF MOTHER'S FEELINGS | | | | | | NOT ASKED |
|-------------|--|-------------------------|---|---|---|---|---|--------------|--|---|---|---|---|---|--------------|
| | | 😊 | 😊 | 😊 | 😊 | 😊 | 😊 | | 😊 | 😊 | 😊 | 😊 | 😊 | 😊 | |
| CAROL | 17 | 7 | | | | | | | ✓ | | | | | ✓ | |
| ANTHONY | 16 | 6 | | | | | ✓ | | | | | | | | ✓ |
| PETER | 15 | 6 | | | | ✓ | | | | | | | | ✓ | |
| ROGER | 14 | 51 | | | ✓ | | | | | | | | | ✓ | |
| PAUL | 13 | 3 | | | | | | ✓ | | | | | | | ✓ |
| IAN | 13 | 51 | | | | | ✓ | | | | | | ✓ | | |
| SARAH | 11 | 6 | | | | | | ✓ | | | | | | | ✓ |
| JENNIFER | 9 | 4 | | | | | | ✓ | | | | | | | ✓ |
| ALISON | 9 | 7 | | | | | | ✓ | | | | | | | ✓ |
| TRACY | 9 | 5 | | ✓ | | | | | | | | ✓ | | | |
| WILLIAM | 9 | 3 | | | ✓ | | | | | | | ✓ | | | |
| MICHELLE | 8 | 51 | ✓ | | | | | | | | | ✓ | | | |
| SIMON | 8 | 2 | | | ✓ | | | | | | | | | | ✓ |
| STEPHEN | 8 | 7 | | | | | | ✓ | | | | | | ✓ | |
| JOHN | 8 | 3 | | | | | | ✓ | | | | | | ✓ | |
| MICHAEL | 8 | 7 | | | | | | ✓ | | | | | | | ✓ |
| SHELLY | 7 | 7 | | ✓ | | | | | | | | | ✓ | | |
| MARTIN | 6 | 51 | ✓ | | | | | | | | ✓ | | | | |
| GARY | 5 | 7 | | ✓ | | | | | | | | | | | ✓ |
| LISA | 4 | 7 | | | | | | ✓ | | | | | | | ✓ |

Dealing with one young person, who had wet one or more beds, was said to influence the atmosphere in the whole household. During the diary keeping Anthony began to experience more dry nights:

"MRS A: I do hope this lasts. Makes the atmosphere and attitude in the house normal!"

Mother of Anthony (age 16) Diary entry

Many parents commented on the difference in the young person's behaviour on wet and dry mornings. On dry mornings the young person's cheerfulness and enhanced self esteem were often manifested as increased communicativeness and on some occasions led to unsolicited activity:

"MRS A: Another good morning. Alison made her bed by 7 a.m. this morning, she was that pleased."

Mother of Alison (age 9) Diary entry

"MRS A: Anthony is pleased with himself. He has tied (sic) up his bedroom for the first time without my asking saying he is 'fed up living in a mess'."

Mother of Anthony (age 16) Diary entry.

5.1.3 Bed time activities

In this section activities that occur at the young person's bed time are described. These relate to the anticipation of the possibility of a wet bed.

From discussions with parents, bed times did not emerge as particularly problematic times in most families, except during family holidays when special preparations were deemed to be necessary to protect someone else's bed. At these times the sense of tension for the young person and their parents was said to be high, in anticipation of a possible wetting episode and the need to explain wet sheets to an outsider if the precautions failed. The special case of preparations at bed time during family holidays is considered in Section 5.4.4. It appeared that at home routines had been established which the young person and their parents were confident would minimise the consequences of bed wetting for the most part and at home no one outwith the family was involved.

In most families the young person's bed was protected with a plastic sheet placed between the mattress and the bottom sheet. This caused many practical problems. Many young people found that they were too hot at night because of the plastic sheet. Lisa's mother described how everyone in the

household had suffered from this as Lisa was one of those children who sometimes wet several beds in one night:

"Mrs L: We all had covers on our beds ... it attracts the heat and everybody's sweating and you cannot sleep all night. So we ended up taking them off our bed, and told her she wasn't to come in to our bed, because we have just got a new bed and I thought 'I cannot keep up with this'".

Mother of Lisa (age 4) 1522117/12 p.6

Many mothers found the plastic sheets difficult to clean and dry and were concerned that there was a residual odour. Two mothers described how the plastic sheets had disintegrated when put in the washing machine! Other mothers had tried scrubbing the plastic sheeting - the result was holes. The odour was even said to remain after the plastic sheets had been wiped down with disinfectant.

In the light of all the practical problems associated with the use of plastic sheeting it is not surprising that some mothers had resorted to putting the young person back into nappies. This practice sometimes started at a holiday time, in the attempt to try to prevent the embarrassment of the young person wetting someone else's bed:

"MRS L: At first it was terrible to try and get her to wear nappies. Oh it was really terrible. As you were putting them on her she was pulling them off. I said, 'Lisa, you have to' - it was on holiday last year we started wearing them. I said, 'You're in someone else's bed' sort of thing. The first couple of nights she greeted (cried), but after that she sort of - 'Oh well, if I've got to wear them, I've got to wear them'. And she has worn them ever since."

Mother of Lisa (age 4) 1522112/38 p.14

The health visitor of Sarah (age 11) had given her nappies to take on a school holiday to save her the embarrassment of discovery, but Sarah's mother had attempted to continue with the practice at home afterwards. Sarah did not express much emotion when the topic came up during conversation:

"SARAH: I wear pads now. So it doesn't wet the sheet and my mum doesn't have all the work."

Sarah (age 11) 1522112/23 p.3

but she had obviously been unhappy about the practice and her mother discovered that she had discontinued with their use.

In conversation about the body worn alarm, which Sarah was refusing to use because she said it was "babyish", the nappies were alluded to again:

"MRS S: She says that ('it's babyish') about the nappies as well and I told her she either stops or she uses them."

Mother of Sarah (age 11) 1522112/111 p.5

Martin's mother had taken an equally uncompromising position:

"MRS M: But I know when my mother-in-law found out, she found out last year and she was horrified. She says, 'get nappies off him and just bring the wet sheets round every day and I'll wash them'. I mean, I get on fine with her, but it wasn't me she said it to, but my husband, and I says, 'If she wants wet sheets every day she can have them because I'm not doing it'. Even now, if he wasn't dry now, he'd be back in them because there's no way, I'm not washing every day! It's bad enough when there is an accident."

Mother of Martin (age 6) 1522112/17 p.2

Three other mothers had tried to shame their sons into being dry by putting them into a nappy on just one occasion. Gary's mother had not persisted with this approach because of the consequences:

"MOYA: ... tell me about nappies.

MRS G: I tried it once wi' him, a year ago, threatened him - I actually put a nappy on him and I thought he was gonnae take a fit, and it was disturbin' tae see him ... I was nearly greetin' (crying) fur him. So that was no go efter that ... You'd think I had killed him. And he was actually heartbroken, and he was embarrassed, and he was - his heid was ready to blow off his shoolders. He was hysterical ... So I just thought, well, that's no' the answer."

Mother of Gary (age 5) 1522112/31 p.17

Alison's mother had been advised by a health care professional to put her daughter into "disabled pads" when she was 5 or 6 years old:

"MRS A: ... that just made her embarrassed. She got totally embarrassed with that and it was not working really. It meant her pad was just wet, not her bed, but she was embarrassed, even more embarrassed than she was with her bed. So we stopped that."

Mother of Alison (age 9) 1522112/11 p.6

When the suggestion to put Alison back into nappies then came from her wider family her mother was not prepared to embarrass her daughter any more.

Shelly's mother had stopped the use of nappies on a regular basis when the little girl was just 3 years old. She said that she had tried it again once or twice when Shelly started school. This did save some wet beds but her mother quickly stopped the practice:

"MRS S: It made her feel too much like a baby."

Mother of Shelly (age 7) 1522112/26 p.16

Several other mothers had discounted the idea of using a nappy for containing the problem as the child grew older, to avoid embarrassing the child, especially once a younger sibling had become dry at night.

Whether through trial and error or intuition the majority of mothers recognised that the use of nappies in children over the age of 3 or 4 was humiliating for the child. Children as young as 4 years old, such as Lisa and Gary, had exhibited signs of acute distress on being put back into nappies after a period of time without them. For those children who were made to wear nappies over a prolonged period, their feelings of embarrassment and shame at bed times can only be imagined as they were reminded of their inability to do what they believed most 3 year olds could do - namely keep their bed and themselves dry through the night.

In this study it has been difficult to gauge whether the anticipation of the possibility of wetting the bed affected the feelings and behaviour of the young people at bed time, when nappies were not in use. As most of the young people were primary bed wetters most mothers had no way of judging whether the uncertainty of what the night might hold (a wet or dry bed) did affect the young person's feelings and behaviour at bed time. They had no bench mark for comparison. However some light was shed on the question when Simon became dry after completing the urinary symptom questionnaire. His mother had no doubt about the effect that being reliably dry for two weeks had had on Simon's demeanour at bed time:

"MRS S: I think he's a changed child in a couple of weeks, quite honestly. If I say to him, 'It's time to go to bed', he goes to bed. We don't have this sort of messing around and getting cross and stomping around. He still does that when he's tired, he's been up late, but he's easier. You're an easier boy (to Simon). You're a happier boy. He comes down in the morning, big smile on his face, he's dry."

Mother of Simon (age 8) 62/70 p.9

5.2 What part do the different family members play in the management of the young person's bed wetting?

5.2.0 Introduction

This section is about the role of different family members in managing the day to day practicalities associated with bed wetting. There are surprisingly few published data on this topic. In particular, little has been reported in the literature on the nature and extent of fathers' and siblings' involvement.

During informal conversations with the researcher the health visitors involved in the recruitment of families to this study were unable to shed much light on this issue from their own professional experience (Section 3.4). Most expressed the belief that the mother had primary responsibility for helping the young person to manage the bed wetting but many commented that they had had little or no professional contact with fathers. They had few ideas about fathers' attitudes to bed wetting, or the extent of the fathers' involvement in the practicalities of care.

Through conversations with the parents in this study and the comments and observations of their children, the varying nature and extent of the fathers' involvement became clearer. Data are presented which suggest that in most families the management of bed wetting is seen by both parents as a natural extension of the mother's child care role (Section 5.2.1). Fathers were not, however, without influence and some had become directly involved in the day to day practicalities of caring in certain circumstances (Section 5.2.2). In this study siblings were found to be little more than bystanders in the practical sense (Section 5.2.3). However, it was discovered that some parents had had to help their own siblings in the past. This experience may have influenced their present attitudes to their own child's bed wetting (Section 6.3.2).

5.2.1 The mother as orchestrator

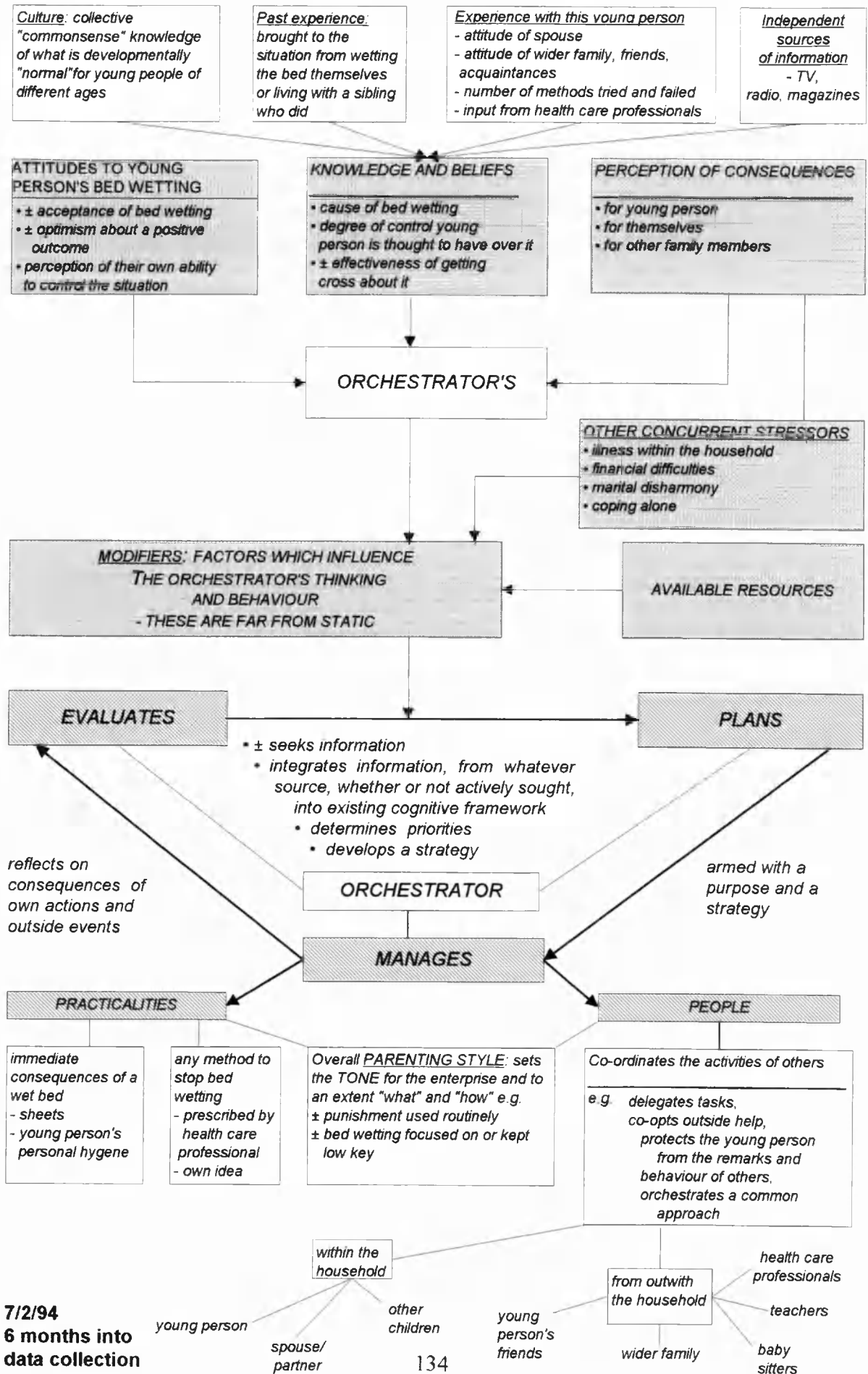
In 17 of the 19 families the mother clearly played the major part in helping the young person with the management of the day to day practicalities arising from the bed wetting (Section 5.1), as well as supervising any treatments tried (Sections 5.5 and 5.6.1). They managed situations involving others

outwith the household such as wider family, friends and health care professionals (Sections 5.4 and 5.6.2). Most mothers acted as the "orchestrator" of events, co-ordinating the activities of people within and outwith the household, as illustrated in Figure 13.

Figure 13 is an example of a logic diagram (Section 3.9.2) developed six months after the commencement of data collection to explore the relationship between emerging concepts. The orchestrator's thinking and behaviour were seen to be influenced by many factors. This logic diagram is a snapshot of the researcher's thinking at a relatively early stage in the study, when contact had only been made with half the families eventually enrolled, yet it contains almost all of the elements of the theory subsequently developed (Chapters 6 and 7). Where Figure 13 is, however, misleading is that it suggests that the behaviour of "orchestrators" is always purposeful and planned. It so happened that most mothers in the first families to be enrolled were actively involved in seeking solutions to the young person's bed wetting at the time of the study. Many had developed a conscious strategy for handling the situation which reflected their beliefs about the cause of the bed wetting and the young person's control over it (Section 5.5). However, it transpired that even within the more proactive families there were long periods when no treatment was actively being sought. At these times the parents tended to fall back on established evening and night time routines (Section 5.5.1). These were, for the most part, supervised by the mother.

In 3 families recruited late into this study there was much less evidence of an overall strategy or of consciously planned action to seek to resolve the bed wetting. The parents in these families merely seemed to be responding to events from day to day (Section 6.3.2). In these families the mother was still responsible for helping the young person with the practicalities arising from the bed wetting. In one case the mother was a lone parent, in the second case the stepfather was only minimally involved and in the third case the father had abdicated from all responsibility for helping with the practicalities of child care, both in relation to the young person's bed wetting and more generally.

FIGURE 13 An example of an early logic diagram:
The orchestrator's role in the management of bed wetting and some factors that can affect it - some dimensions of an ever changing reality



In this study 11 mothers did not have paid employment of any kind. However, seven had part time jobs (Table 6). In some cases this affected their ability to help the young person. One mother was an over-night garage attendant and on the nights when she worked child care automatically devolved to her husband. Five of the mothers had part-time cleaning jobs and in two cases this involved early morning work. These mothers left the house between 5.30 and 6.00 a.m. and their children were cared for by an adult male relative who only played a minor role in the management of any bed wetting episodes. In these cases the children were largely left to their own devices from 5.30 a.m. onwards (Section 5.2.3). The nature of these mothers' employment also affected their availability to help the young person with treatments prescribed by health care professionals, such as the body worn alarm (Section 5.6.1).

The socialisation of women into the role of "mother" has been described, for instance, by Graham (1982, 1983, 1986, 1993); Oakley (1979); Urwin (1985) and Wetherell (1995). In every society there are certain implicit and explicit expectations of a mother's behaviour. In her book *The Ideology of Motherhood* Wearing (1984, p.49) describes the "good" mother:

"A good mother is one who is always available to her children; she gives time and attention to them, listens to their problems and questions and guides them where necessary. She cares for them physically ... She is calm and patient, does not scream or yell or continually smack her children. The cardinal sin of motherhood with its associated guilt is to lose one's temper with a child. Self-control should be exercised at all times. Even in extenuating circumstances ... when the mother has no emotional or physical support in her task, she must at all times be in complete control of her own emotions."

Wearing acknowledges that an unrealistically high standard is set by such an ideal. It suggests that the mother should always put the young person's interests above her own.

Wetherell (1995) suggests that the mother is seen by society as the parent who is primarily responsible for a child's welfare and is expected to provide consistently high quality parenting, regardless of the degree of social and relational stress she is experiencing. Wetherell suggests that failure to live up to the ideal can result in a mother feeling guilty and a failure. Many of the mothers in this study expressed feelings of guilt after they had punished their child for wetting the bed

(Section 5.5.3) and two mothers said that they felt that others blamed them for the young person's bed wetting (Section 5.6.2).

Overall the mother's role in the management of the young person's bed wetting was not seen to be an easy one. The consequences of bed wetting could make physical and emotional demands on mothers at key times of communal family activity, such as the morning rush for school (Section 5.1.2). There were also social and emotional consequences of the bed wetting for family relationships more generally, when a mother could find herself in the role of arbitrator (Section 5.4.1).

5.2.2 The father's role

From talking with parents and the young people in this study five patterns of paternal involvement emerged:

- the father was rarely, if ever, involved
- the father was occasionally involved in a few specific ways
- the father had become increasingly involved in the search for a solution to the bed wetting but the mother was largely responsible for managing the practicalities from day to day
- the mother and father shared both the overall responsibility and the day to day care on an equitable basis, according to their availability
- the father had abdicated responsibility for care and "didn't want to know", leaving the mother to manage alone.

In four of these five patterns the mother was regarded by both parents as being in overall control. Four young people had two father figures in their lives, their natural father, with whom they stayed on occasion, and a step-father or the mother's male partner with whom they stayed for the majority of time. This gave rise to a sixth pattern of occasional paternal involvement. Examples of each pattern of paternal involvement and the context in which each arose are described below.

Ten of the twelve fathers interviewed for this study said that they were rarely or only occasionally involved in caring for their bed wetting child in the practical sense:

"MOYA: And how about the practicalities of the bed wetting - are you ever aware when William's wet the bed?

MR. W: Yes, aye, quite often I wake up, maybe before Lorna certainly, but I usually just wake up Lorna. She does that ... I don't really do anything to do with that ... I just book the holidays, so to speak (laughs)." (William's father was a travel agent)

Stepfather of William (age 9) 156/2 p.3

Shelly's father was a garage mechanic:

"MOYA: Do you get involved at all?

MR S: No. She does (he laughs, looking at his wife). I'm out there (in his garage) near enough 24 hours a day.

Father of Shelly (age 7) 156/35 p.9

Three mothers commented that their partners were not available for child care of any kind because they worked long hours. In two cases, where the parents were divorced, the mother said that the natural father had taken no part in the care.

Four mothers said that the father was, or had in the past, been occasionally involved in specific ways, most usually in lifting the child at the parents' own bed time. The father's involvement in this way occurred in some families once the young person was too heavy for the mother to lift (Section 5.5.1). Occasionally the father's help was invoked if the mother felt that a firmer hand was needed.

The data suggest that as the young person grows older, some fathers become more involved in seeking solutions to the problem at their wives' request. The mothers in these families were still said to be responsible for the day to day practicalities:

"MR P: Well, Louise (his wife) basically is the one that's dealing with Peter most of the time. When there's been - when I've come in at night and we've tried to waken him up - things like that - that's really my involvement in it. My involvement's not been a great deal."

Father of Peter (age 15) 156/2 p.7

Fathers in this category were, however, said to be willing to help if asked.

Only two fathers in this study were said to have consistently shared responsibility for managing the everyday consequences of the young person's bed wetting. Paul's mother had suffered from post-natal depression after both her sons were born and Paul's father had taken a great deal of responsibility for caring for his sons, in practical ways, since they were babies. In the only other case where a father had accepted many of the day to day responsibilities associated with the bed wetting,

the father had been unemployed for three years. His wife worked part time and he had taken on many of the domestic tasks. This family was particularly accepting of the situation (Section 6.3.2). Both parents shared the same philosophy, as well as the care. When asked what advice they would give to other parents, they said:

"MR I: There's no point in taking it out on the wean (child).

MRS I: It's not their problem, it's not their fault.

MR I: It's going to stop.

MRS I: It's just waiting."

Parents of Ian (age 13) 14213/40 p.1

The sense of partnership was reflected in these parents' replies to many questions. Ian's mother had wet the bed herself until she was 11 or 12 years old.

Three fathers were not as involved with the young person's care or as supportive of their wives as were the fathers of Ian, Paul, Anthony and Peter, nor indeed, did it seem that they wished to be.

These fathers were said by the mothers to be very angry about the bed wetting, to want it to stop, but to want nothing to do with helping it to stop. They didn't want to know. In two cases the father was said to have little positive involvement with the child in other ways:

"MRS G: Alan's never been a part of their life as in taking them away tae a park, or takin' them a walk, or takin' them tae visit his family - the bairns' life revolve round me, 24 hours a day."

Mother of Gary (age 5) 131/3 p.10

Another father was said to have resented the attention that the young person had received from his wife:

"MRS C: My ex-husband didn't like the idea of me getting up out of my bed, lifting her up to the toilet and putting her back. He didn't like that at all. He said she was nothing but a lazy - he called her lazy ... I said leave her and she'll come out of it. He wanted me for himself."

Mother of Carol (age 17) 131/13 p.8

Carol's father wet the bed himself:

MRS C: It was worse when he had a drink in him ... It was two or three times a week sometimes, and I says - and he kept shouting at me, at Carol, lifting Carol to the toilet."

Mother of Carol (age 17) 131/40 p.8

After separating from his wife and leaving the family home, this father sexually abused his daughter for three years, from the age of 11 to 14 on her weekend visits to him and he was imprisoned for it.

In each of these three families the relationship between the parents was said by the mother to be or to have been poor and the tensions in the house were said to be or to have been high. In each case the young person was thought by the father to have more control over the bed wetting than he or she was choosing to exercise and all these children had been punished for it over a prolonged period (Section 5.5.3).

The involvement of fathers no longer living within the household

At the time of this study four young people had two father figures in their lives, their natural father, with whom they stayed on occasion and a stepfather or the mother's male partner with whom they stayed for the majority of the time. A further four young people no longer saw their natural father (Section 4.2).

In those cases where the mother had re-married or had a new partner she was quite clearly the orchestrator of events, co-ordinating the activities of others within and outwith the household. Two mothers, who were against the use of punishment for bed wetting, felt that the natural fathers' attitude was unhelpful when the children stayed with them at weekends:

"MRS S: ... I don't think his dad and his gran were particularly clued into what the problem was and he was put back into a nappy one time, and then I think there was a bit of a stigma if there was a wet bed ... Messages like, 'Well I'm not going to wash the sheets every night' sort of thing, didn't help things. In fact it was a disaster."

Mother of Simon (age 8) 131/19 p.3

"MRS J: I was taking them back, like, (after a weekend visit to the natural father) and he used to crack up with them because they'd wet the bed, and I said, 'You used to do it'. He says, 'Aye, I ken, but I still -'. He was angry at them because they wet the bed."

Mother of John and Stephen (twins, age 8) 131/37 p.2

It is worthy of note in the second example, that the unsympathetic father was known to have been a bed wetter himself. It was not known whether Simon's father had wet the bed. In this study there is evidence to suggest that most mothers who were bed wetters themselves were particularly accepting of their child's predicament, whereas some fathers who had been bed wetters were clearly not (Section 6.3.2).

The father's role in child care more generally

The findings of this study are congruent with the findings of more general research into child care, which shows that the mother normally has most responsibility for child care on a day to day basis (Darling-Fisher and Tiedje, 1990; Demo and Acock, 1993; Gelles, 1995; Graham, 1993; Major, 1993; Muncie et al, 1995).

During the last thirty years men's participation in the paid labour force has significantly declined while the proportion of married women in the work force has risen sharply, albeit mostly in part time employment (Hood, 1993). The most striking change has been the increase in employed mothers, especially the mothers of babies and pre-school children (Hoffman, 1989; Menaghan and Parcel, 1990). During this time there has been an increasing interest in the father's role in child care (e.g. Biller, 1993; Cohen, 1993; Daly, 1993; Gelles, 1995; Haas, 1993; Hood, 1993; Lewis and O'Brien, 1987; Muncie et al, 1995; Stier and Tienda, 1993). However, there is some disagreement among researchers about the extent to which men's involvement in household work and child care has increased in the last three decades during the time when women's working lives have changed dramatically.

Some studies have found a slight increase in the proportion of family work undertaken by husbands whose wives are employed (Pleck, 1985). Other researchers claim that there has been little increase in men's house work and child care activities (Coverman and Sheley (1986). Kooreman and Kapteyn (1987) and Goldscheider and Waite (1991) found that even in homes where both husband and wife worked, the wife undertook more of the household work and child care activities.

Rexroat and Sheehan (1987) found that women worked longer hours than men at every stage in the family life cycle but especially when the family included children under three years old. "Work" included both paid employment and looking after the home and children. This unequal division of labour was confirmed by Hochschild and Machung (1989) who calculated that many wives were working an extra "shift", amounting to nearly an extra month of work per year.

Both parents worked full time in only one of the 19 families in the present study. In this family the wife was clearly responsible for all matters relating to child care although her working day was at least as long as her husband's. In the present study all but two of the mothers regarded themselves, and were regarded by their husbands, as the principal carer in the practical sense. Management of bed wetting did not seem to be regarded as a special case but as a natural extension of the mother's more general child care role.

It has been found that mothers spend more time than fathers with their children in middle childhood and adolescence (Russell and Russell, 1987) as well as in early childhood. Stafford and Bayer (1993) suggest that even once their children are largely self-caring mothers talk with their children more and over a greater range of topics than is the case for most fathers. They suggest that fathers' conversations are characterised by a control function, and are concerned with issues of discipline and setting boundaries, while mother-adolescent interactions are more likely to involve personal and social issues. In the present study while many parents remarked that they talked with their children about their bed wetting from time to time, the researcher wondered whether some young people felt able to talk about their bed wetting with anyone at all within the family (Section 6.5.2).

A review of the recent literature suggests that within and across cultures the expectations of fathers are more varied than the expectations of mothers (Section 5.2.1). "Good" fathers have been variously defined as: patriarchs, disciplinarians, moral educators, educators about the ways of the world, their children's best friend and substitute mothers (Harris and Morgan, 1991; Biller, 1993; Cohen, 1993; Daly, 1993; Deutsch et al, 1993; Haas, 1993; Holland, 1994; Hood, 1993; Ishii-Kuntz, 1993; Stier and Tienda, 1993). Haas (1993) clearly describes the influence of social policy on the father's role in Sweden. Culturally defined expectations of fathers to take equal responsibility with their wives for many aspects of child care in Sweden contrasts sharply with the authoritarian ideal in Japan where child care is seen almost exclusively as the mother's role (Ishii-Kuntz, 1993). Expectations of fathers in Britain seem to lie somewhere in between.

5.2.3 The involvement of siblings

All the young people in this study were living in families with at least one brother or sister. This section is about the involvement of siblings in the practicalities arising from the young person's bed wetting.

As members of a family with a young person who wet the bed siblings were at the least observers of events and were often affected themselves, directly or indirectly. The practical consequences were greatest for the seven children who shared a bedroom with a bed wetter (Section 5.3.1), however no children in this study shared a bed. Some siblings may have received less attention in the morning rush for school as the parents were engaged elsewhere (Section 5.1.2). Some were disturbed in the night when the young person was receiving treatment with a body worn alarm (Section 5.6.1). Many were undoubtedly affected by the practical arrangements relating to family holidays, and the restrictions imposed on choice and type of holiday (Section 5.4.4). However few were involved with the management of the practicalities arising from the bed wetting from day to day in anything more than a passing way.

None of the young people in this study shared a bed with a sibling, but two younger sisters of one of them did and one of them was a bed wetter. The one who did wet the bed described her sister's obvious displeasure at her bed wetting:

"MOYA: ... What does Linda say when she wakes up and finds a wet patch? ...

ANNE: She fights with me."

Anne (age 7) younger sister of Roger (age 14) 3223/30 p.1

William's mother could still clearly remember what it was like to share a bed with a bed wetter:

"MRS W: I was actually sharing a bed with her, because she was younger and we were, you know, all in the same room, and she used to wet me ... I can remember I used to get up and I'd say, 'oh, not again!', and she used to sit there and say, 'I'm really, really sorry. I had a dream I was going to the toilet, and I was still in my bed!'"

Mother of William (age 9) 1813/20 & 29 p.1

It could be that in some parts of Britain it is more common for children to share a bed than was the case in this study (Karandikar, 1992). Such bed wetters face the potential disapproval of their siblings on every occasion when the bed is wet, which could well reinforce their feelings of

embarrassment and shame. It is impossible, however, for a young person to avoid the censure of others, even when they only share a room. Michelle's mother could remember what it was like to share a room with a bed wetter until her sister was 14:

"MRS M: It was hard, we shared a room, you could smell the bed in the morning, and it was horrible ... In the mornings you could see her making the bed and I would go and say 'is your bed dry?' 'Oh aye' but she was hiding it, she was getting embarrassed about it."

Mother of Michelle (age 8) 1813/8 p.2

The maternal grandfathers of William and of the twins, John and Stephen, were said to have abdicated all responsibility for the management of the bed wetting in the way that some fathers in this study were said to have abdicated responsibility (Section 5.2.2). The consequences for William's mother, her bed wetting sister and their mother were particularly far reaching and lasted for nearly six years. This is a case where a sibling had a special part to play in the day to day practicalities:

"MRS W: She got to about 8 or 9, and my father said, 'look, you know, this is it, she's going to stop and you'd better make her stop' - and my mother was left to you know sort of arrange it herself, and what she actually did was, she got a buzzer for her, but it used to be a big pack machine ... I don't know how it worked because my mother never had it on, because when the buzzer went off it was an almighty zzzzzzzzzzz - like a siren - she couldn't use it because my father would have heard it and then he would have known that she hadn't still stopped wetting the bed. My mother covered it up - it was a big secret ... my mother couldn't even wash the sheets or anything when my dad was in because then he would have known. I couldn't go through and knock my mother's door in the middle of the night because then he would have known. I used to have to get up with her, change her, change the bed, put the two of us back into bed ... and my mother used to put you know sheets and everything in the bottom of the cupboard so I could just get up without my dad knowing. So of course my dad lived in blissful ignorance from about the time she was 8, and she never stopped till she was 14, and it was hidden ..."

Mother of William, talking of her own sister's bed wetting and her involvement with it, 156/20 p.2

This was the only example to be uncovered in this study of secrecy being maintained within a subsystem of the family. William's mother clearly described the anxiety and tension that this situation created for her mother, her sister and herself. It is extraordinary that the women in the house managed to keep the secret for so long. Paternal intolerance to bed wetting was discovered in the present study (Sections 5.2.2 and 6.3.2). The above historical example may not merely be a reflection of a by-gone era.

5.3 What are the social consequences of bed wetting from the young person's perspective?

5.3.0 Introduction

The social consequences of bed wetting are reviewed in this section from the young person's perspective, with special reference to the consequences for the young person's relationships with siblings and friends. The social consequences for the family as a social unit are described in Section 5.4. It was discovered that many young people had to face the censure of their siblings from day to day, especially if they shared a bedroom (Section 5.3.1). Most young people were afraid of the consequences of people outwith the household discovering that they wet the bed. Some young people denied that even their closest friends knew about the bed wetting, which was a closely guarded secret (Section 5.3.2). Many young people were anxious about staying away from home and reluctant to have friends to stay for this reason (Section 5.3.3).

5.3.1 Relationships with siblings

All the young people in this study were living in families with at least one brother or sister. Fifteen (75%) had a younger brother or sister. Thirteen had a younger sibling who was dry at night. Nine of the young people shared a bedroom with a sibling, and five of the nine shared a bedroom with a younger sibling who was dry at night. One child shared a bedroom with a younger sister, who also wet the bed but was not enrolled into this study. These data are summarised in Table 11.

Most of the young people were very hesitant in their response to any questions about how their siblings felt about the bed wetting. Five said that their younger brothers and sisters did not know about it (Table 11). The faces-feelings cards (Appendix VIII) proved to be a particularly helpful way of introducing this sensitive topic. To retain the option of privacy in the presence of others, adolescents like Peter were sometimes given a card to read for themselves:

TABLE 11 The young people's sleeping arrangements and their perception of sibling's feelings about their bed wetting

| YOUNG PERSON | AGE | YOUNGER SIBLING DRY | SHARES BEDROOM WITH SIBLING | | | YOUNG PERSON'S PERCEPTIONS OF SIBLING'S FEELINGS | | | | | | | DOESN'T KNOW | NOT ASKED |
|--------------|-----|---------------------|-----------------------------|-----|-----------|--|----------------|---|---|---|-----------------|----------------|----------------|----------------|
| | | | YOUNGER DRY | WET | OLDER DRY | NO | 😊 | 😊 | 😊 | 😊 | 😊 | 😊 | | |
| CAROL | 17 | + | | | | ✓ | | | | | | ✓ ^e | | ✓ ^e |
| ANTHONY | 16 | + | | | | ✓ | | | | | | | ✓ ^e | |
| PETER | 15 | + | | | | ✓ | | | | | | | | |
| ROGER | 14 | +/ ^a | ✓ | | | | ✓ ^f | | | | | ✓ ^e | | |
| PAUL | 13 | + | | | | ✓ | | | | | | ✓ ^e | | |
| IAN | 13 | + | | | | ✓ | | | | | | ✓ ^e | | |
| SARAH | 11 | NA ^b | | | | ✓ | | | | | | | | ✓ ^b |
| JENNIFER | 9 | NA ^b | | | | ✓ | ✓ ^f | | | | | | | ✓ ^b |
| ALISON | 9 | NA ^b | | | | ✓ | | | | | | | | |
| TRACY | 9 | - | | ✓ | | | | | | | | | ✓ ^e | |
| WILLIAM | 9 | + | | | | ✓ | | | | | | ✓ ^e | | |
| MICHELLE | 8 | + | ✓ | | | | | | | | | | ✓ ^e | |
| SIMON | 8 | - ^c | | | | ✓ | ✓ ^f | | | | | | | |
| STEPHEN | 8 | + | | | | ✓ ^d | | | | | | | ✓ ^e | |
| JOHN | 8 | + | | | | ✓ ^d | | | | | | | ✓ ^e | |
| MICHAEL | 8 | NA ^b | | | | ✓ | | | | | | ✓ ^f | | |
| SHELLY | 7 | + | ✓ | | | | | | | | ✓ ^{ef} | | | |
| MARTIN | 6 | + | ✓ | | | | | | | | | | ✓ ^e | |
| GARY | 5 | + | ✓ | | | | | | | | | ✓ ^e | | |
| LISA | 4 | NA ^b | | | ✓ | | | | | | | | | ✓ ^b |

Notes: + = YES - = NO ^a one younger sibling wet the bed and one was dry; ^b no younger sibling; ^c baby, 8 months old; ^d twins, who share with each other
 NA = not applicable ^e referring to younger sibling(s) feelings; ^f referring to older sibling(s) feelings

"PETER: I'll just leave that one - 'how do you think your brothers and sisters feel?'"

Peter (age 15) 3223/18 p.2

Peter said that his younger half brother (aged 2½) who was already dry at night, was "too young" to know about it, a fact denied by his parents in a later conversation:

"MRS P: You were asking Peter the other night, 'what do the rest of the family feel about it?' And he said, 'och, Stuart's too young' - and I thought I should have said to you then, Stuart's even said to him - 'Oh, is Peter's bed wet?' because he's even paying attention to it now ... if I go through and if I change it the odd time, and I strip it or whatever- 'Peter's wet his bed - you're not supposed to wet your bed, are you' - I say - 'no'"

Mother of Peter (age 15) 132/21 p.6-7

Seven other young people chose the middle face to describe how their siblings felt about the bed wetting. When attempts were made to explore the meaning of choosing the middle face, three young people were hesitant to elaborate on their response and looked obviously embarrassed so the topic was dropped. The remainder said that their brothers and sisters accepted their bed wetting for the most part as a fact of life.

Three young people suggested that their older siblings were happy about the bed wetting. Jennifer (age 9) said that her sisters, who were much older than her, were happy because they were not, for the most part, inconvenienced by it. However in two cases older siblings were said to be happy because they were able to use the bed wetting as an opportunity to "score points":

"MOYA: How does your oldest brother feel about it?"

ROGER: Happy, so he can slag me."

Roger (age 14) 3223/56 p.1

Many of the young people felt vulnerable to being put down by older siblings because of the bed wetting.

The two children who felt that their younger brothers and sisters were very unhappy about the bed wetting shared the same bedroom:

"MARTIN: ... he doesn't like me wetting the bed.

MOYA: Does he not? What does he say to you?

MARTIN: 'Go away, Martin'."

Martin (age 6) 3223/51 p.1

Shelly (age 7) believed that her brother and sister were unhappy about the bed wetting too and they called her names. The negative attitude of many siblings to the young person's bed wetting may well reinforce the young person's feelings of embarrassment and shame (Section 6.4.2). It is a situation from which there is no easy escape, especially in those families whose sleeping accommodation is limited and sharing a bedroom is unavoidable.

5.3.2 The fear of discovery and rejection by others

Maintaining secrecy was high on the agenda for most of the young people in this study. This became apparent even in response to a question about the young person's feelings about taking part in this study:

"IAN: I'm not bothered what folk kens as long as my pals don't find out."

Ian (age 13) 3214/70 p.2

When asked what their special friends felt about the bed wetting five of the young people said that none of their friends knew, three evaded the question and five gave a non-committal reply (Table 12).

Two young people, who admitted that they had a special friend who knew, spontaneously added that they were sure that this friend would keep the knowledge a secret:

"MOYA: Do any of your friends know about it? (he shakes his head) ...

How do you think they would feel if they did know?

JOHN: Well there's one of my pals that knows, that's my really really best friend and he's not opened his mouth ... He doesn't say anything. He just - (long pause).

MOYA: Do you ever talk about it?

JOHN: I talked about it - I says to him once, 'how would you feel if you wet the bed?' and he said he would feel the same as what I feel.

John (age 8) 3226/127 p.1

"MOYA: Do any of your friends know about it?

MICHELLE: One friend ... Cos, I know I can trust her. And she says, 'Right, I'll tell not one person'. She always tells me the truth ... she says 'You have to stop it, everybody will find out sooner or later'".

Michelle (age 8) 3226/11 p.2

Peter and Michael found it hard to talk to any friends about it even, in one case, when the friend was also a bed wetter:







"PETER: Before I moved here I had a best friend - he done exactly the same - he knew, we knew each other.

MOYA: Yes. So you talked about it?

PETER: No! We never talked about it! - we just knew we did.

Peter (age 15) 3226/27 p.2

TABLE 12 The young people's perception of the feelings of their special friends about their bed wetting

| A G E | USUAL FREQUENCY OF BED WETTING ^a |       | | | | | | NONE OF THEM KNOW | DON'T KNOW | NOT TICKED ON CARD | NOT ASKED |
|-------------|--|--|---|--|----------------|---|--|-------------------------|---------------|-----------------------------|--------------|
| | | | | | | | | | | | |
| CAROL | 17 | 7 | | | | | | | ✓ | | |
| ANTHONY | 16 | 6 | | | | | | | | | ✓ |
| PETER | 15 | 6 | | | | | | ✓ | | | |
| ROGER | 14 | ≤1 | | | ✓ ^c | | | ✓ ^b | | | |
| PAUL | 13 | 3 | | | ✓ | | | | | | |
| IAN | 13 | ≤1 | | | | | | | | ✓ | |
| SARAH | 11 | 6 | | | ✓ | | | | | | |
| JENNIFER | 9 | 4 | | | | | | ✓ | | | |
| ALISON | 9 | 7 | | | | | | | | | ✓ |
| TRACY | 9 | 5 | | | | | | ✓ | | | |
| WILLIAM | 9 | 3 | | | ✓ | | | | | | |
| MICHELLE | 8 | ≤1 | | | | ✓ | | | | | |
| SIMON | 8 | 2 | | | | | | ✓ | | | |
| STEPHEN | 8 | 7 | | | | | | ✓ | | | |
| JOHN | 8 | 3 | | | | | | | | ✓ | |
| MICHAEL | 8 | 7 | | | | | | ✓ | | | |
| SHELLY | 7 | 7 | | | | | | ✓ | | | |
| MARTIN | 6 | ≤1 | ✓ | | | | | | | | |
| GARY | 5 | 7 | | | ✓ | | | | | | |
| LISA | 4 | 7 | | | | | | | | | ✓ |

Notes: a nights per week b first response c second response

MICHAEL: ... friends normally tell everybody about things - but I don't tell my friend about it.

Michael (age 8) 3226/40 p.3

Although there was a known cause for the bed wetting, Michael, a very sociable child, was still reluctant to talk about it with his closest friends. As with the other young people he felt ashamed about a problem over which he believed he had no control.

In the light of the response of their siblings in some cases (Sections 5.2.3 and 5.3.1) and the humiliation experienced when bladder control was lost in public in the day time, the reason for the desire to maintain secrecy was not hard to imagine:

MRS J: I had to go up to the school. He was saying that the teacher wasn't letting him out to the toilet. But when Stephen needs, he needs. He's just got to go. I had said to her at the beginning of the year, that he needed to go. And he was coming in and he was wet. And it got to the stage that he was coming home greeting (crying). He was coming home, breaking his heart and he was wanting long tops to hide it because they were all making fun of him, but she wasn't letting him out - 'do your work first', and he was slow anyway, ken."

Mother of Stephen (age 8) 17225/21 p.1-2

Roger commented with some feeling on the injustice of the social consequences of bed wetting for an older person:

"ROGER: And I saw a film about this old guy who pee'd the bed at night, and his family wouldn't have him, and his wife and all that died, and he had kids. And they wouldn't let him stay with them ... and I was shouting at the film, 'it's not right, it's not right!'"

Roger (age 14) 32110/85 p.1.

Great care was taken in this study not to raise the possible long-term consequences of bed wetting with these young people and their parents (Section 3.5.5). By the time of this study, Roger was fortunately nearly dry and the problem was perceived by him and his family as nearly over.

It is not known whether any of the other young people had gained any insights into the possible long-term consequences of bed wetting, such as social isolation and homelessness (Section 2.2.4). Sarah's mother had asked the age range of the young people taking part in this study. In response to the reply "5 to 20 years old" she said that if Sarah was still wetting the bed when she was 20, she would be "out of the house". There is no way of knowing how seriously this comment was made, or what Sarah's mother would do if that time came.

5.3.3 Problems relating to staying away from home and having friends to stay

When asked what the best thing would be about being reliably dry five young people gave a social benefit. They said that they looked forward to being able to have friends to stay or to being able to stay away from home without fear of discovery. Even when the bed wetting seemed to be well controlled, the fear of loss of control was still at the back of some young people's minds:

"IAN: You ken you'll no' wet the bed with that Desmospray, but you're just worried a wee bit in case you do - it doesn't work, or something".

Ian (age 13) 323/59 p.3

Jennifer was really looking forward to staying away from home when she was dry but as things were she was reluctant to take the risk:

"JENNIFER: I can't really stay at my friend's house ... she always asks me to stay at her house, and I say 'No'. And she asks me why, and I say 'I just don't like staying at other people's houses'."

Jennifer (age 9) 323/48 p.3

The literature on the psychosocial consequences of bed wetting for young people emphasises their negative feelings about staying away from home (Section 2.2.4) but in this study seven young people (35%) said that they enjoyed their trips away. Two of the seven were amongst the most frequent bed wetters. It may be that the seven young people who enjoyed staying away from home were doing so in an uncritical environment, where those around them had learned to cope unobtrusively with the bed wetting or it could be that for these young people the social pleasures of staying away from home outweighed any fear of discovery. It was not merely age related. Although most of the young people who were happy about staying away from home were aged nine or younger, other children of the same age were unhappy about doing so. It has not proved possible to explain fully the polarity of feelings about staying away from home expressed by the young people in this study, but it did appear that those who were reluctant to stay away, while a dry bed could not be assured, were those who feared or had come most to fear the consequences of discovery. This could be as much related to their personality as to the positive or negative nature of any actual experiences of staying away from home that they had had. It is also possible that some young people had learned to fear possible humiliation when staying away from home from their parents' reluctance to let them go (Section 5.4.2).

5.4 What are the social consequences of bed wetting for the family as a social system?

5.4.0 Introduction

This section draws together many of the themes highlighted in Sections 5.1 - 5.3 by considering the consequences of bed wetting for relationships within the family and the outside influences impinging on the family as a social unit.

The conceptualisation of the family as a social system is described in Section 2.3.2 where four characteristics of the family are explored, namely:

- wholeness - the concept that no one element can be understood in isolation from other system elements
- the interdependence of system elements
- the presence of subsystems within the system e.g. the marital dyad, sibling subsystem and parent-child subsystems, and
- the opposing purposes of maintaining the status quo and adapting to change.

The effects of one young person's bed wetting are not confined to the young person and their principal carer but can impinge on everyone living within the household (Section 5.1). No family member is totally in control or totally divorced from the actions of other family members, however much they may attempt to take charge of or to distance themselves from the situation. While the mother is, in the main, responsible for managing or supervising the day to day practicalities which arise when a young person wets the bed (Section 5.2.1), the father is affected by the bed wetting, both directly and indirectly and exerts an influence through what he says or does not say and through what he does or does not do (Section 5.2.2). Siblings can also be affected in many ways, whether or not they share a bedroom with the young person who wets the bed (Sections 5.2.3 and 5.3.1).

Family systems theory suggests that behaviours are evoked between and among members through a dynamic process of mutual simultaneous shaping (Section 2.3.2). The processes of communication within the family and the mutual influences of the messages that parents convey to young people and

the parent's interpretation and construction of the young person's response are explored in Section 6.5.3. The present section begins with a brief review of the place of bed wetting on the family's agenda and the effect of a young person's bed wetting on relationships within the family (Section 5.4.1). Parents' unease about letting the young person stay away from home is described in Section 5.4.2. The consequences arising for the young person and the family from the attitude of wider family and friends is discussed in Section 5.4.3. The problems for the family in relation to staying away from home are described in Section 5.4.4.

5.4.1 The place of bed wetting on the family's agenda and its effects on relationships within the family

As the "architects" of the family (Yorby et al, 1995 p.16) parents are generally in overall control of the family as a social unit and determine, to a considerable extent, the priority assigned to items on the family's agenda. The priority assigned to a young person's bed wetting by the parents may not reflect its priority in the eyes of the young person who may be, or feel, unable to articulate the depth of his or her concern about it.

The distinction therefore needs to be made between bed wetting as an issue of collective family concern, which is largely identified as such by the parents and bed wetting as an ongoing cause of concern for most young people, who may remain silent, feeling helpless to do anything about it themselves and reluctant to discuss it within the family because of their feelings of embarrassment and shame (Section 6.4.2).

At the time of the study, the parents of Ian, Shelly and Simon said that they did not regard the young person's bed wetting as an issue in the family:

"MOYA: So how big an issue is it in the family now?

MR I: It's not.

MRS I: It's not an issue at all."

Mother and father of Ian (age 13) 1216/38 p.4

Parents in most of the remaining families said that they were frustrated by the bed wetting and wanted it to stop but said that they had accepted, or had come to accept it, as a fact of life:

"MRS W: The way I look at it is, it's a problem that will solve itself eventually, we don't know how long it will take, but eventually he will come out of it. So there's no point in getting upset."

Mother of William (age 9) 1216/23 p.2

These parents believed that one day the bed wetting would stop, even if they could not be sure when this would happen (Section 6.3.2). However, one or both parents in each of these families recounted one or more times in the family's history when they had been less philosophical about the bed wetting which had then been placed much higher on the family's list of priorities for action:

"MRS M: I had went to the doctor and I'd went to the health visitor and I feel I've asked that many people that I can about the situation. It was like - it had become an obsession. It really was a problem. It wasn't just once a night, but if anyone had come in and he was sitting with a nappy on - wandering about in his nappy ... I thought that there would be no end to this! That's how down I was because I thought, 'This is never going to end!'. It was quite a big thing in our lives."

Mother of Martin (age 6) 1216/8 and 19, p.3-4

The mothers of Alison and Jennifer had felt equally desperate and helpless until they realised that the young person had no control over the situation and they had also come to believe that the problem would resolve itself in time. Before coming to this realisation, the mothers of Martin, Alison and Jennifer had punished their children for wetting the bed and there was said to have been a great deal of tension in these households on 'wet' mornings.

Some parents said that the bed wetting had been a particular problem for them and for relationships within the family in the past at a time or times when other stressful events were occurring. At these times the young person's bed wetting could become a focus for angry exchanges between the parents:

"MRS L: At first it caused a lot of rows because he thought - he was worse than me - she's lazy, she's this and that, she's not getting any more juice. But now it's just another part of life. It's not a great big deal any more."

Mother of Lisa (age 4) 1612/44 p.2

Five of the mothers in this study said that they had had a long-standing health problem which at times pushed the bed wetting up their agenda, because of their reduced ability to cope with it.

A cause of tension within the household which was directly attributable to the young person's bed wetting was the cost of the extra laundry and the practical problems of drying bedding in winter time in Scotland. This was a particular cause of concern for families when they were short of money.

The situation was particularly acute for Michael's parents because of his chronic renal problems which included both day and night time wetting, but three other parents also commented on the burden imposed by the extra laundry costs:

"MR I: We go through the washing machines (laughs)

MRS I: An awful lot of washing machines, that's for sure!"

Mother and father of Ian (age 13) 15118/25 p.2

The way in which one young person's bed wetting could affect the relationship between siblings is described in Sections 5.2.3 and 5.3.1. In one family sibling rivalry also seemed to have affected the relationship between each young person and the mother. The parents were well aware of the situation:

"MRS A: (aside to Susan) Why do you pick on him for it? You'll make money out of it.

SUSAN: How do I? Make money? (sounds very affronted)

MRS A: Not money - you make - what's the word I was thinking of? When you have brother and sisterly love, when you try to score points against your brother -

SUSAN: Oh well, he scores points off me as much as I score points off him!"

Mother and sister of Anthony (age 16) 132/19 p.1

Anthony had been wetting the bed six nights per week on average at the start of the study according to the urinary symptom questionnaire, but this fell to an average of two nights per week for the month of the diary keeping. His mother said that during this month she had given her son extra attention and affection but that this had had an unfortunate and unforeseen side effect:

"MRS A: Anthony felt good about it himself and dry again. Still getting on well with Anthony but Susan seems to feel left out as she and I have always had a good relationship. You can never win, can you?"

Mother of Anthony (age 16) diary entry

It transpired that Susan had been annoyed by the extra attention that Anthony had received during the diary keeping and had, at one point, refused to say more than the occasional word to her mother. Anthony's mother felt that she was being forced to choose between her children. She valued her close relationship with her daughter. After the diary keeping was completed, Anthony reverted to wetting the bed nearly every night of the week. The possible reasons for this are explored more fully in Section 6.5.2.

The 'meaning' that Susan attached to the extra attention that Anthony received from their mother during the diary keeping altered Susan's behaviour towards her mother and ultimately the behaviour

of this mother towards her son. This is a good example of Yerby et al's (1995) suggestion that family members are connected to one another by "rubber bands". Movement between two members of the family can cause re-alignment of all family members but if this movement is opposed, as it was by Susan, relationships can revert to the status quo.

In the light of the data presented throughout this chapter it is suggested that any understanding of the nature of a family's experience of bed wetting and their responses to it need to be seen in the context of relationships within the family more generally. This has important implications for practice, especially where pre-existing family dynamics could hinder the creation of a supportive environment for the young person to learn, or relearn the skill of becoming dry at night (Chapter 7).

The data support the findings of Haque et al (1981) and Devlin and O'Cathain (1990) that not all families are equally concerned about the young person's bed wetting (Section 2.2.4). The negative and pervasive consequences of bed wetting for some families in this study are at one extreme but important end of a continuum of experience. At the other end of the continuum there are some families who regard themselves as unaffected or only minimally affected by the bed wetting. Most families seem to be at a point on the continuum somewhere in between these two extremes.

5.4.2 Parents' unease about letting the young person stay away from home

Many parents in this study said that they had felt uneasy about allowing the young person the social freedom of staying away from home. Many expressed the concern that the young person would be hurt by the reaction of others to the bed wetting:

"MRS R: His pals keep asking him to stay there and he just cannot, he cannot take the risk ... If they found out about it, that would be it, they would start making a fool of him."

Mother of Roger (age 14) 15321/28 p.3

Some parents also commented on the embarrassment to themselves arising from the need to forewarn others of the possibility of a bed wetting episode. The embarrassment was said to arise because of other people's expectations:

"MRS W: People expect, if he's nine, that he should have been out of that years ago. Whereas I mean I know from my sister that my sister went on till she was about 14, so it just doesn't work that way."

Mother of William (age 9) 15321/42 p.1-2

William's mother had at first refused to let her son stay with a friend because she didn't know his friend's mother personally and she was not sure what to say to her. She described how she had had to explain the situation to William:

"MRS W: I had at first said, 'no, I don't think so', and he sort of looked at me you know and I said, 'do you know why you're not going?' and he said, 'Uhha, it's 'cos I wet the bed'. I says, 'well it's just that it's another lady and she's got wee kids of her own, and then if she's got you as well and you go and wet the bed,' I says, 'it's too much work.' 'What if I really try?' I said, 'well, okay'."

Mother of William (age 9) 15321/15 p.1

Like several other parents William's mother said that she had relented when she realised how much her son wanted to stay away, so she had prepared the way for him and his friend's mother was said not to have been disapproving when William did wet the bed. Alison's mother had also taken special care to discuss the practicalities with the adults involved before allowing her daughter to stay away from home.

Thanks to the understanding and accepting attitude of the adults acting *in loco parentis* William and Alison were not made to feel embarrassed and ashamed of their bed wetting. There were, however, many other examples where the young person's bed wetting had been the object of obvious disapproval. This disapproval manifested itself in several ways. Sometimes the young person was not invited back again. In other cases the disapproval was less subtle.

Anthony's parents had been hesitant about letting their son go on a school trip abroad, because of the bed wetting and their worst fears came true:

"MRS A: At 7 o'clock one morning we had a phone call from Germany to say that Anthony had wet the bed!

MR A: Well I think it was a bit more explicit than that! ...

SUSAN: Mummy was threatening to have him flown back and things.

MRS A: I was hysterical. I have friends who have relatives out there -

MR A: What can you do at 7 o'clock in the morning, from 700 miles away?

MRS A: Exactly. They were prepared to go and to pick him up and bring him back, and that's how bad it was - that's how bad I felt about it. Fancy phoning up at 7 o'clock - about a situation I already knew, that I was on tenterhooks about anyway."

Mother, father and sister of Anthony (age 16) 12141/12 p.1

Anthony was very publicly humiliated in front of his peers. In fact Anthony's whole family was humiliated by this experience and the parents had felt helpless to intervene because he was so far from home. This and similar stories illustrate how much young people and their families are at the mercy of the attitude of others.

The effect of such incidents on a young person's self-esteem may be considerable. Certainly, such incidents were long remembered by the whole family. There may be much justification for parents' reluctance to allow a young person who wets the bed to stay away from home without them.

5.4.3 Families' experiences of the attitudes of wider family

Many young people's first experience of staying away from home without their parents involves going to stay with relatives who live nearby. This might seem a safer option than entrusting a young person to adults who are not so well known to the family, but for some young people this was not an available option. Three mothers said that their relatives were not happy about having the young person to stay until the bed wetting had stopped:

"MRS L: Nobody will let her stay, she doesn't stay at her auntie's because she wets the bed, not that I think she would, because she would be embarrassed by somebody else putting a nappy on."

Mother of Lisa (age 4) 13324/35 p.1

Lisa had in fact stayed with her aunt on one occasion when her mother was in hospital. She had wet the bed and had been afraid to tell anyone.

When analysing the attitudes of grandparents to the young person's bed wetting an inter-generational tendency was observed. In two cases where the grandparents were intolerant of the bed wetting the parents (their children) held a similarly intolerant view:

"MRS T: My mum'll not let her stay especially - she says she's a bed wetter. She says when - 'once you stop that you can come and stay here'."

Mother of Tracy (age 9) 13311/49 p.5

In contrast, in several other cases the parents and grandparents appeared to be equally tolerant of the situation:

"MRS P: Well, my father, he's a GP and you know he's very relaxed about everything, and so well, he's quite supportive you know... His other grandparents I think are quite relaxed about it ..."

Mother of Paul (age 13) 13311/19 p.6 and 13322/21 p.1

In Shelly's family there seemed to be a general acceptance of the bed wetting:

"MRS S: All the family and that know ...

MOYA: And what's the family attitude to it?

MRS S: Not really blaming her, but just, they've just accepted it as well.

Mother of Shelly (age 9) 135/15 p.4

Although she was unhappy about the bed wetting Shelly was happy about staying away from home (Section 5.3.3).

Anthony's grandmother had been particularly sympathetic and had told her grandson that she too had been a bed wetter. She had revealed to her grandson a personal secret which she had not told her own children, with the specific purpose of helping him to feel that he was not alone. Some aunts who had wet the bed themselves were equally sympathetic and reassuring to the young person:

"MRS W: She's standing there and she would say, 'You will grow out of it, son, and you will, and everything will be OK. Auntie Betty used to wet the bed as well when she was a wee girl, and when she was a big girl she did as well!' - you know - she adds this on - you know - what she's really saying to him is she's gone through it, she was him, but she's come out of it now on the other side."

Mother of William (age 9) 13314/37 p.1

Although she was not herself a bed wetter Gary's aunt had adopted a similar attitude to the little boy, when he stayed with her .

The few uncles whose views were commented upon by the parents seemed to have been less sympathetic with the young person than the aunts were, in a way which is reminiscent of the more negative feelings expressed by some fathers, especially those fathers who had wet the bed themselves (Section 5.2.2). Problems could arise when a male relative came to stay. William's mother strongly disapproved of her brother's attitude:

"MRS W: Their (men's) attitude is, he should have stopped wetting the bed. And my brother's really bad for that, cos he comes home from college at the weekends ... and he says 'You know you should be out of that by now and you're going to be a man soon, we can't have you wetting the bed' ... Gives him - you know - five minutes, you know - macho talk, and floats out and sees him in a month's time you know ... Oh, I've told him, I said 'I don't want you talking to him like that', you know, because I think, well, he probably won't take any notice, but then again he might."

Mother of William (age 9) 13313/27 and 35 p.1

The above is a clear example of maternal protectiveness. There were other examples of a mother protecting a bed wetting child from his or her adult male relatives, including the young person's father.

While most parents believed that the young person was unaware of the negative attitudes of relatives to the bed wetting it would be surprising if at least some of these young people had not become aware of these attitudes, whether through overhearing conversations, through non-verbal cues such as a disapproving face, or indirectly when they were not invited to stay.

This section ends with a brief review of the social consequences of bed wetting for the family as a whole when on holiday together.

5.4.4 Problems associated with staying away from home as a family

It is perhaps not surprising in the light of the foregoing description of some young people's experiences of staying away from home that many of the families said that they chose self-catering holidays when they went away together as a family, to avoid the embarrassment of having to explain the situation to other people. Several parents commented that such a holiday required some extra preparations such as packing extra sheets and an extra duvet or a sleeping bag. The inconvenience of extra laundry when away from home and home facilities was mentioned by several parents.

So concerned were some young people and their parents about the possibility of a wet bed that they slept very poorly indeed when away from home:

"MRS J: ... basically I think she's frightened to sleep.

JENNIFER: I sort of sleep with one eye open!

MRS J: Basically I think, if we go anywhere like a hotel or that, she is frightened to sleep. I'm like that as well and I feel you just don't enjoy it."

Jennifer (age 9) and her mother 12142/25 p.3

Jennifer's mother said that she often fell asleep in the afternoons when on holiday. This was rather reminiscent of the experience of Michael's mother when at home (Section 5.1.1). It is not surprising,

perhaps, that many families said that they felt more tired after the holiday than before it. The inability to relax at night time was an obvious contributory factor.

When families did stay in hotels or bed and breakfast accommodation a factor which emerged as a major determinant of the nature of the experience was the attitude of the people with whom the family stayed:

"MRS M: We used to go camping - we had a trailer tent - this year we went to a hotel - but the people knew the situation and they were fabulous - they were really good. We always take our own bedding and an extra duvet and whatnot, but - the man was absolutely wonderful with him. Michael doesn't eat when he's not feeling well, he'll eat nothing, and poor Dave was making things for his dinner, you know, special things whereas it was, you know, the evening meal, Dave said, 'Right, come on Michael, what will we have?' And he'd make him something special."

Mother of Michael (age 8) 12142/11 p.4

It would seem that Michael, who was recognised as having no control over his bed wetting because of his kidney problems, had captured the heart of the hotel owner, Dave, as he had won the sympathy and affection of the taxi driver and many members of the local community at home.

Sarah's mother suggested that her daughter's bed wetting was not acceptable to others because there was no obvious physical cause for it:

"MRS S: I have a urinary problem but people understand that, but then I'm an adult, and I've got MS - that is acceptable. Sarah's is not acceptable to most people.
MOYA: Is that your feeling or is it what they have said to you?
MRS S: It's not so much what they say, it's what they don't say. You know, like in the morning 'Is everything all right? Are the sheets all right?' It's not 'Has she wet the bed?' but, you know, 'Do I have to wash the sheets?' kind of thing, you know. Or one friend who we stayed with quite a lot, she'll say 'I would put her in with my daughter but I'm kind of worried in case Sarah has an accident'."

Mother of Sarah (age 11) 12142/38 p.2

The effects on the young person's self image and self esteem of other people's negative evaluations of them as a bed wetter are discussed further in Sections 6.4.2 and 6.5.2. A major determinant of other people's attitudes seems to be the extent to which the young person is perceived as having some control over the situation.

5.5 What do parents do of their own volition to encourage the young person's bed wetting to stop?

5.5.0 Introduction

The results of surveys reported by Devlin (1991), Foxman et al (1986) and Haque et al (1981) support the impression gained in this study from speaking with health visitors that many families with a bed wetting child rarely if ever seek help from health care professionals. These families may therefore rely on methods which they devise for themselves and the suggestions of wider family and friends in some cases. None of the methods commonly employed by lay people has a good track record of success and in some cases the methods are likely to hinder the attainment of dry nights (Section 2.2.3).

The methods most commonly used by the families in this study were restricting the young person's fluid intake before bed time, lifting the young person to use the toilet at the parents' own bed time and waking the young person in the night (Section 5.5.1). Almost all parents had also tried to encourage the young person's efforts by using various incentives (Section 5.5.2) and many had also punished the young person for bed wetting (Section 5.5.3).

5.5.1. Modification of evening and night time routines

Lifting and waking the young person at the parent's bed time and in the night

With only one exception the parents of all the young people in this study said that, at one time or another, they had tried lifting the young person and taking them to use the toilet at their own bedtime in an attempt to keep the young person from wetting the bed through the night (Table 13). Lifting the child at their own bed time had been one of the few specific tasks undertaken by those fathers who were only occasionally involved in care (Section 5.2.2).

TABLE 13

Methods used by the families to encourage the bed wetting to stop

| A G E | Modification of evening routine | | Complementary medicine | | Methods suggested by health care professionals | | | |
|-------------|---------------------------------|----------------|------------------------|--------|--|---------------|----------------|-----------------------------------|
| | Restricting fluids | Lifting | Hypno therapy | Herbal | Star chart | Alarm Bedaide | Body worn | Medication Imipra- Tryptizol mine |
| CAROL 17 | ✓ ^a | ✓ | | | ✓ | | ✓ | ✓ ^a |
| ANTHONY 16 | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| PETER 15 | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ ^a |
| ROGER 14 | ✓ ^a | ✓ | | | ✓ | | ✓ | ✓ ^a |
| PAUL 13 | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ |
| IAN 13 | ✓ | NK | | | ✓ | | ✓ | ✓ ^a |
| SARAH 11 | ✓ | ✓ | | | ✓ | | ✓ | ✓ ^a |
| JENNIFER 9 | ✓ | ✓ | | | ✓ | | ✓ ^a | |
| ALISON 9 | ✓ ^a | ✓ | | | ✓ | | | |
| TRACY 9 | ✓ ^a | ✓ | | | ✓ | | ✓ | |
| WILLIAM 9 | ✓ | ✓ ^a | | | ✓ | | ✓ ^a | |
| MICHELLE 8 | ✓ | ✓ ^a | | | ✓ | | | |
| SIMON 8 | ✓ ^a | ✓ ^a | | | ✓ | | ✓ | ✓ ^a |
| STEPHEN 8 | ✓ ^a | ✓ | | | ✓ | | ✓ ^a | |
| JOHN 8 | ✓ ^a | ✓ | | | ✓ | | ✓ ^a | |
| MICHAEL 8 | ✓ | ✓ ^a | | | ✓ | | | |
| SHELLY 7 | ✓ | ✓ | | | ✓ | | | |
| MARTIN 6 | ✓ ^a | ✓ | | | ✓ | | ✓ | ✓ ^a |
| GARY 5 | | | | | ✓ | | | |
| LISA 4 | ✓ | ✓ ^a | | | ✓ | | | |

Notes:

NK = NOT KNOWN

^a in use at the time of the study

^b Probanthin

^c placebo

In conversations with parents the most striking finding was that some parents had persisted with this method for anything up to eight years and had only stopped the practice when the child was too heavy to lift. Most parents said that lifting the child did save the occasional wet bed and were thankful when the contents of a full bladder had been voided in the appropriate place:

MRS S: Sometimes ... you were lucky. It is quite a quantity. We're not talking about a little dribble here, we're talking about a full bladder and that is amazing. You know, I used to think 'Oh thank goodness that is not going to be in the bed!' (laughs)."

Mother of Sarah (age 11) 1522114/132-133 p.3-4

The young person's lack of awareness of events and the extent of their disorientation on being lifted in the night was commented upon by several parents. Some young people were said to be placid but others were decidedly obstreperous and could resist the parent's attempts at waking them:

"MRS C: Well, the doctor told me to wake her up at night time to go to the toilet, but she loses her temper with me and she keeps telling me to - says bad words! She doesn't like getting annoyed. She doesn't like getting up."

Mother of Carol (age 17) 1522114/1 p.11

Peter was so desperate to be dry that he had pleaded with his mother to wake him in the night, even once he was too heavy to lift:

"MRS P: But it just didn't work because you know he would get up and then he would slam a door and - he really was grumpy when he got up.

Mother of Peter (age 15) 1522114/44 p.5

Alison's mother had been advised to use an intensive waking schedule. This involved her in setting an alarm at one and a half hour intervals throughout the night. She persisted with the method for two months but the bed wetting had continued:

"MRS A: In the end she was going to school tired and greeting (crying) and she was still wetting the bed, and she was tired. ...It ended up that she was tired and I was tired so we gave that up!"

Mother of Alison (age 9) 1522114/8 p.4

Many parents were persisting with a method which they knew to be of limited value:

"MRS L: We lifted two or three times a night, but she still managed to wet. She still managed to wet the bed. We used to lift her but I've even seen us lifting her one night and within ten minutes she's doing the toilet and within ten minutes she's wet."

Mother of Lisa (age 4) 1522114/5 p.13

Other mothers commented that the young person could wet the bed within an hour of being lifted. At the time of the study Lisa's mother's diary entries showed that she was still lifting the little girl during the night when she herself was having difficulty in sleeping. It was as though these parents were falling back on a habitually used practice and persisting with a method of limited value because they knew of no better way to deal with the situation and had discovered that health care professionals also had a limited repertoire of responses (Section 5.6). Several parents did, however, comment on a benefit arising from adopting this strategy. They said that doing something made them feel less helpless than doing nothing, even if what they did do was not particularly effective.

Restricting fluid intake before bed time

Restricting a young person's fluid intake after a certain time in the evening is a commonly reported practice among parents (e.g. Bollard and Nettlebeck, 1989; Haque et al 1981; Butler, 1987). This method was being used by eight families at the time of the study and with one exception it had been tried by all the parents in the study at one time or another (Table 13). As with lifting, some parents had persisted with this method for many years. The parents of seven young people said that restricting the young person's fluid intake had always been their practice.

Most young people were given their last drink at their tea time at around 5-6 p.m. Some mothers even restricted fluid intake at this time. Most young people seemed to have accepted the practice, but perhaps some had not been given very much choice:

"MRS M: He accepts it, he does, he doesn't stand and create for any more. If he did, I wouldn't be giving him it."

Mother of Martin (age 6) 1522113/23 p.3

Peter's mother had been told by her health visitor that restricting fluids was an unhelpful practice but she commented that her son had continued with the practice of his own volition for some time afterwards. Other young people, however, regarded the discrimination as unjust:

"CAROL: And I turn round and say 'it's not fair. If Allan can get a drink after 7 o'clock, I should'. I'm not allowed to drink after 7."

Carol (age 17) 1522113/35 p.7

As with lifting, the parents said that they had persisted with the practice of restricting fluid intake at night even when it seemed to make little or no difference to the outcome:

"MRS T: She doesn't get drinks after 6 o'clock ...
MOYA: And have you always done that?
MRS T: I've always done that.
MOYA: And do you find that that makes any difference?
MRS T: No."

Mother of Tracy (age 9) 1522113/3 p.7

Restricting fluid intake in the evening seems to be another example of parents falling back on a response based on habit, in the absence of knowing of anything more effective to try . Unlike lifting and waking the young person at the parents' own bed time, restricting the young person's fluid intake carries with it potentially harmful side effects (Butler, 1994) and is likely to increase the risk of urinary tract infections as one mother had come to realise for herself:

"MRS S: Well, she would waken up and she'd - 'I've got a sore bottom, it's burning' (tearfully). What do you do for that? You give them a lot of liquid! ...So this is something we've had to live with as well. A lot of problems with urinary infections."

Mother of Sarah (age 11) 1522113/142 p.3

Sarah's mother had abandoned fluid restriction after only six months for this reason. Michelle's mother commented on how concentrated her daughter's urine was as a result of the fluid restriction in the evening and she had also stopped the practice. Involving as it does, minimum inconvenience for the parents, this method might, however, be particularly difficult to discourage in some families.

Other methods devised by parents

Some parents had devised other methods for themselves. When she thought that the problem could be that her son was sleeping too deeply to wake up to a full bladder, Peter's mother had tried removing some of the bed-clothes so that he would sleep more lightly . Carol's mother had thought that her daughter might sleep more lightly in a noisier environment and she had conducted an experiment to test her hypothesis:

"MRS C: I tried a wee experiment on her, right? I told her to go in to the front room for a wee bit ...

CAROL: I wondered why the room was cold in the middle of the night when she woke me up. She always opened the window because she kent the fire engines came past the window. She got up to check me to see if I was awake, and here was me still lying on my bed, the same way, not moved a muscle yet.

MRS C: So that didn't work.

Carol (age 17) and her mother 1522115/90 p.2

These experiments are an indication of some parents' attempts to take control in a situation where all the methods suggested by health care professionals had failed (Table 13, Section 5.6). These initiatives, while memorable to the families, were usually short-lived and merely punctuated prolonged periods when the only methods that they used were known to them to be of limited usefulness such as lifting the child and restricting fluids. Parents' lack of success with their own methods was often said to have contributed to their feelings of helplessness. However, most parents had not totally given up hope that a solution to the problem would be forthcoming.

Another approach very commonly employed by parents was to use a system of rewards to encourage the young person to take more responsibility for becoming dry at night, as is described below.

5.5.2 The use of rewards

All parents said that they had used rewards at one time or another as an incentive and this was said to have been the first method tried by some parents. The mother of the twins resorted to the use of rewards when she was told by health care professionals that they could do nothing to help until the boys were seven years old:

"MRS J: ... I thought, 'Oh God, I've got to wait to seven!', ken? Then that was when I started myself, like the bribery, the rewards."

Mother of John and Stephen (age 8) 15221212/71 p.1-2

She had tried offering sweets, toys, days out and bigger rewards such as a bike or a computer game at Christmas. None of "the bribery" worked and she had found it very difficult to offer the rewards in a consistent way:

"MRS J: Half the time I gave in. 'But you said we were to get it'. 'Only if you didn't wet'. 'I didn't wet'. 'Oh, take it!'... I gave in quite a lot, just for peace and quiet."

Mother of John and Stephen (age 8) 15221212/54 p.1

Peter's mother had found it difficult to be consistent too, especially when the system of rewards and penalties became rather elaborate:

"MRS P: We had a system at one point, and saying, 'right, we'll give you 50p for each dry night', and it got to the stage that he was quite happy to take the odd 50p he'd get, so the other side of the system that - 'right, you get 50p when you're dry, and I'll take something off when you're wet'!

MR P: (laughter) So he was in debt! In an overdraft!

MRS P: It just all got very complicated - and you say, you know, 'well, if you can crack - if you can be dry for a month I'll buy you ..' and I knew I was on a dead bet because he never ever managed it".

Mother and stepfather of Peter (age 15) 15221212/53 p.4

The fact that Peter was 'happy to take the odd 50p he'd get' suggests that Peter had little conscious control over the situation and only achieved the occasional dry night and then by chance, in spite of the offer of tangible incentives to encourage him to make a special effort.

It was some young people's inability to achieve any dry nights, and the resulting disappointment, which had led the parents of three children to stop the practice of offering rewards altogether:

"MRS L: ... She's getting up in the morning and the first thing is she's looking if she's wet and she's maybe going about with her face tripping on her and we have a wee tear, 'I cannae get'".

Mother of Lisa (age 4) 15221212/52 p.4

On the advice of the health visitor Alison's mother had adopted a system whereby the rewards offered would increase if more dry nights were achieved:

"MRS A: ... She couldn't manage it at all, even with the idea of having a very special present at the end of a week. No, it didn't work at all, I'm afraid. She wanted it but she just couldn't manage it ... and that just disappointed her more really. Became really downhearted when she got up in the morning and the bed was wet, no chance now, sort of thing. So we stopped it, it didn't seem to be doing any good. I think the pressure was too high on her. 'I've got to be dry'. She was trying hard but it didn't work."

Mother of Alison (age 9) 15221212/38 p.2

Simon's mother had also recognised that the offer of a reward, whether by herself or the health visitor, had made the stakes too high and had resulted in Simon hiding his wet night-clothes. She had interpreted this as the sign of his desperation to be dry and his distress at not achieving this goal.

The mothers of Alison, Simon and Lisa discovered from experience that the offer of rewards for dry nights was inappropriate for their children, who were wetting the bed seven nights per week. This has important implications for practice as it may be that the offer of even very small rewards for dry nights is inappropriate for those young people who wet the bed most frequently.

The inability to achieve more than the occasional dry night, for those young people wetting the bed six or seven nights per week, may well reinforce their sense of failure at achieving a task that they believe that most three year olds can accomplish and contribute to the young person's feelings of helplessness to influence the situation however hard they try (Section 6.4.2). Many young people attribute the odd dry night that they do achieve to chance and not to their own efforts, as their efforts

are so rarely rewarded with a dry bed. It may well be that failure to attain a specially coveted reward such as a bike or a computer game adds to the young person's distress.

The offer of a large reward for a prolonged period of dry nights, mentioned by several parents, is not only unrealistic and unlikely to be successful as a motivational aid, it is also effectively a form of punishment in that an unattainable reward is in effect a privilege withheld:

"MRS T: My mum had taken this boy (Tracy's brother) to America when he was 9, and she says, 'if you stop wetting the bed, Tracy, I'll take you'."

Mother of Tracy (age 9) 15221213/27 p.1

A more subtle form of punishment was hinted at by Sarah's mother when discussing Sarah's motivation to be dry:

"MRS S: Well the motivation, if it is strong enough, is to please mum or to please dad, you know, it's not for themselves. Sarah comes to me, her eyes a-twinkle, 'I've not wet the bed tonight, mum'. I say, 'That's brilliant', and she'll give me a big cuddle - she's rewarding me!"

Mother of Sarah (age 11) 15221211/47 p.2

It would seem that Sarah wanted her mother's approval more than money, bikes or computer games, which were the rewards most commonly offered by parents for dry nights. Sarah's mother had punished her daughter for wetting the bed in the greatest variety of ways reported on in this study. She had used shaming and tirades, physical punishment, withdrawing privileges such as watching favourite TV programmes and threatening to throw away her daughter's clothes. Parents' use of punishment to discourage the young person's bed wetting is described below.

5.5.3 The use of punishment

"MOYA: How do you feel about punishing children who wet the bed?"

HV A: Well I think that's inappropriate, but I can quite see why people do. I think it would be very easy just to give the child a quick slap round the ear hole, but I don't recommend it and I would certainly frown on it, but I think as a human being I can quite see that I might easily do the same."

Health Visitor A 14213/51 p.1

An analysis of parents' feelings about bed wetting showed that the majority of parents felt frustrated at times with what they regarded as a never ending problem. Some parents said that they felt angry with the young person for not making sufficient effort to help themselves to overcome the problem. Parents from two families went so far as to suggest that the young person deliberately wet the bed on some occasions (Section 6.3.2).

When analysing the data about parents' use of punishment there seemed to be a close correlation between parents' negative feelings about bed wetting and the bed wetting child, their perception of the young person's control over the phenomenon and their use of punishment. The use of various forms of verbal and non-verbal punishment has been found in this study to be much more widespread than the literature suggests (Section 2.2.3).

Parents in 13 of the 19 families in this study (68%) said that they had punished their child for wetting the bed on some occasions. Five mothers said that they had used physical punishment, especially when they thought that the child was being lazy or when they themselves had felt particularly frustrated with the problem:

"MRS J: Sometimes I would slap her out of sheer anger or frustration .. I used to scream and shout and then that was it."

Mother of Jennifer (age 9) 1521228/27 p.2

"MRS C: I spanked her. I used to smack her a lot for doing it. Well I used to smack her quite a lot when she started to do it. I used to shout at her and stop her having any sweets and it still didn't work."

Mother of Carol (age 17) 1521228/63 p.1

What Carol's mother had not realised at the time was that her daughter was being abused by her natural father when she stayed with him at weekends, after the parents had separated. Even at the time of this study, three years after the abuse had stopped and the father had been imprisoned, Carol was angry and felt that her life was boring and unpleasant. By the time of this study Carol's mother and stepfather had come to a pragmatic acceptance of the bed wetting although they were anxious that it should stop (Section 6.3.2).

Tracy's mother was finding it very difficult to cope alone with four children and she too had used physical punishment until only a few months before the study when her health visitor had discovered about Tracy's bed wetting when carrying out a developmental check on one of the younger children:

"MRS T: I do - I did hit her at first - I used to get up in the morning and hit them - but it was Doreen (health visitor) that spoke to me, she says, don't Ann,' she says, 'I know I'm getting on tae ye, but it's going to make it worse. She says, 'I understand what you're going through'.

Mother of Tracy (age 9) 1521228/36 p.2

In two families a punitive approach was said to have originated from the father but had not had the desired effect of bringing about dry beds. For Gary's parents the difference in their approach to the use of physical punishment had become an issue within the family:

"MRS G: We're arguing about it all the time. To hit him willnae solve the problem - to hit him doesnae make any difference. The health visitor says to me, 'you've like got to continually ignore it'. You can only ignore it for so long, and it just boils over, - but I didnae hit him for it. And he thinks he should get hit all the time for it, but I dinnae think so, cos he doesnae know that he's wet the bed at night."

Mother of Gary (age 5) 1521228/42 p.2

Encouragement to punish the child physically was said to have come from other family and friends in some cases:

"MRS A: My mum ... had the old belief that wetting the bed was 'lazyitis', that skelping her bum would soon stop it, but it didnae work. We just gave her rows, we didnae spank her, we just gave her rows, ken, 'you're dirty', ken, 'this is not on', sort of thing. But it was no' working, so after two or three days we stopped it. That wasnae having any effect."

Mother of Alison (age 9) 1521228/7 p.1

Rows, shaming, and shouting at the young person in the morning, on discovering a wet bed, were far more commonly reported than the use of physical punishment:

"MRS M: I must admit we used to - did used to get on to him now and again about it, because it got to us. We never never hit him or anything for it because - but we used to really - we were quite firm with him. The odd morning we'd maybe shouted at him a wee bit, but it wasn't his fault. He didn't do it to annoy me or anything, he just couldn't help himself. Just one of these things."

Mother of Martin (age 6) 1521228/44 p.1

Four mothers said that they had tried to shame the child into trying to be dry:

"MRS T: And I would say to Tracy, 'look at Kerry Ann, she's a lot younger, she's not even at school', - ken I've tried to put that intae her but she's just no."

Mother of Tracy (age 9) 1521228/14 p.6

"MRS S: And I try and shame her with this smell. But she's not ashamed of it! We don't have a problem with it."

Mother of Sarah (age 11) 1521228/15 p.3

Sarah's mother was concerned that if she took the clinical psychologist's advice and played down the problem Sarah would think that wetting the bed was normal.

Some fathers were also said to have tried the approach of shaming the child. Such an approach conveys the message to the child that she could be dry if only she tried harder, yet through repeated failure to become dry, the young person may have come to believe that nothing that they do makes any difference (Section 6.4.2).

One instance of shaming had gone into family "folklore". It was recognised at once by the mother as having been a mistake:

"MRS A: When he was little, because he was such a messy toad, we left ... all the clothes, we left everything in his bedroom. He came out of the doorway and said, 'mum, I haven't got any pants', 'Well, here you are, son', and I got the frilliest pair of pink knickers I could possibly get and I said, 'these are the only pair I've got, they're your sister's, you'll just have to wear them till you clear your bedroom out'.

SUSAN: And he had peed that day.

MRS A: I didn't know that. And he wore a pair - that was the worst thing I could have done. Even that didn't embarrass him into doing it.

Mother and sister of Anthony (age 16) 1521228/98 p.5

Young people were said to have been threatened with not being allowed to start primary school unless they stopped wetting the bed, or with having their wet clothes destroyed. At his wits' end, one father had threatened his four year old with sleeping in the bath:

"MRS R: It was really bad. It wasn't just as if the bed was getting wet, it was absolutely getting saturated. I was getting through that many beds with him. In the - he ended - he used his own bed and his brother's bed so we ended up with him on the floor on a mattress- it was the only way we could do it."

Mother of Roger (age 14) 1521228/2 p.12

The way in which several young people had been embarrassed and humiliated when their mothers put them back into nappies to contain the problem is described in Section 5.1.3.

In contrast to the above accounts, eight mothers said that they did not believe in punishing a child for bed wetting, although they might punish the young person for other misdemeanours, including daytime wetting when the young person was thought to have some control.

Ten of the 19 mothers in this study had either been a bed wetter themselves or had experience of living with a bed wetting brother or sister (Appendix XIII). Six of the eight mothers who said that they did not believe in punishment for bed wetting came from this group. Two of these mothers said that in their experience punishment caused needless distress and was ineffective. They gave this as the reason why they had not punished their own child for bed wetting:

"MRS J: If they need, like normal behaviour, if they need a skelp they get a skelp. But not for bed wetting, because you know I went through it and my Dad was hard on us and it never made any difference. Whereas we just felt really bad for wetting the bed and we were feared to say we had wet the bed, because he was quite stern about it and that. Once or twice we got skelped for it because none of his were bed wetters, not his brothers or his, ken - just us and we were bed wetters."

Mother of the twins, John and Stephen (age 8) 15221227/41 p.1

The way in which William's mother and maternal grandmother had ultimately kept her sister's bed wetting a secret from an intolerant father for six years is described in Section 5.2.3. This experience may well have influenced this mother's attitude to her own son's bed wetting:

"MRS W: ... and my father used to be quite upset about it, it was a sort of ongoing argument - it just made my sister all the more nervous, and I can remember her saying, 'don't let me sleep tonight because then I'll wet the bed and I won't know, and I'll get a row in the morning', and I thought, I'll never put my kids through that, you know."

Mother of William (age 9) 15221227/10 p.1

While the mothers of the twins and William were against the use of punishment because of the adverse effects they had seen it could have, as well as its lack of effectiveness, Shelly's mother said that she would not punish her daughter because she herself had not been punished. Ian's parents felt that he had no control over the bed wetting and that punishment was therefore inappropriate. Simon's mother held a similar view:

"MOYA: Have you used any punishments at all?

MRS S: Punishments? No" (sounds astounded)

MOYA: How do you feel about punishment? You sounded aghast.

MRS S: I think that would have worked adversely ... it's too negative, isn't it? You have got to be positive about it. I wouldn't punish."

Mother of Simon (age 8) 14213/64 p.1

For Simon's mother punishment was a totally inappropriate approach.

In summary, two thirds of the young people in this study (13 out of 20) were said to have been punished for wetting the bed on some occasions. Five out of the 20 (25%) were said to have been physically punished. Verbal punishment and withholding of privileges were much more commonly reported. The data suggest that parents who feel that the young person cannot control the bed wetting are far less likely to use punishment than parents who believe that the young person has some control over it.

Mothers who have experience of bed wetting themselves or have lived with a bed wetting sibling are generally less likely to punish their child than mothers with no previous experience of bed wetting, unless they believe that the young person can help it. Mothers who have no previous experience of bed wetting may not punish their child if they believe that punishment is an inappropriate approach. More fathers than mothers felt that the young person had some control over the bed wetting, which they were not choosing to exercise (Section 6.3.2). Fathers can influence the decision to use physical punishment and they may use it themselves against the mother's judgement.

5.6. What are the families' experiences of the methods suggested and the help received from health care professionals?

5.6.0 Introduction

This section describes families' experiences with methods suggested by health care professionals to encourage the young person's bed wetting to stop, in particular the use of charts linked to incentives, body worn alarms and medication (Section 5.6.1). Parents' evaluation of the help received from health care professionals is given in Section 5.6.2. The consequences arising when parents and health care professionals run out of ideas are described in Section 5.6.3 from the families' perspective.

5.6.1 Families' experiences of methods suggested by health care professionals

Charting progress and the use of incentives

At one time or another all the young people in this study had recorded their progress towards being reliably dry at night, using some form of chart (Table 13). Usually incentives were linked to the achievement of one or more dry nights. Various incentive regimes had been suggested to parents by health care professionals including stars and progressively larger rewards for more dry nights. The health care professionals' involvement in this way often formalised an approach which parents had adopted for themselves. Some of the problems associated with the use of rewards to motivate young people to take responsibility for becoming dry are described in Section 5.5.2. The present section focuses on family members' experiences with the charts themselves.

Some children were said to have embarked on the use of a chart with optimism and enthusiasm:

"MRS S: He was always excited coming home with his new charts and stars and whatever, weren't you? (to Simon). I think you just got frustrated with them because they weren't working."

Mother of Simon (age 8) 1522211/62 p.3

Seven young people were said to have made some progress while they kept a chart:

"MRS G: The psychologist gave me a star chart ... that worked for three weeks, then it was, the novelty wore off for him and there just wasnae any fun in it for him any mair.

Mother of Gary (age 5) 1522211/40 p.17

All the parents said that in the end the young person had given up when their progress was not sustained.

For four young people incentive charts were said to have been a cause of disappointment from the start. Stephen's mother described the chart as "useless" and Shelly's mother as "a waste of time". Each of these young people was wetting the bed seven nights per week and could not achieve even one dry night. In sympathy Lisa's mother had given her a star sometimes "for being a good girl":

"MRS L: She knew that it wasn't right (to receive the star), so that went in the bucket."
Mother of Lisa (age 4) 1522211/51 p.15

Lisa's mother was not encouraged to persist with the idea of using charts because of the way that her efforts had been discounted when she took Lisa to the hospital with chart in hand (Section 5.6.2):

"MRS L: I had started a star chart and I took it up to the hospital and they just looked at it as if I was stupid, as if 'we'll no' be needing that' because it was lucky if there one star on it.

Mother of Lisa (age 4) 1522211/6 p.14

For Peter (age 15) and Sarah (age 11) an important issue had been where to put the chart to avoid their friends coming upon it by chance. Sarah had kept a chart diligently at first but had been put off using it when someone had commented upon it:

"MRS S: "I'm not having that up on the wall and people will think I'm babyish. It's going away. You don't get stars when you are a big girl, you only get stars when you're in Primary I'. Which is true. Do you ever see stars in anybody's reading book in Primary V and VI? I don't think so."

Mother of Sarah (age 11) 1522211/57 p.4

The inappropriateness of stars as an incentive was also commented upon by the mothers of Tracy and Martin:

"MRS M: He wasn't awfully interested in that, it wasn't something he thought like getting a star at school and that. It didn't do a lot for him."

Mother of Martin (age 6) 1522211/31 p.3

Martin and his mother tried the chart for a week. In Tracy's household the method had lasted for two days:

"MRS T: She's no' using it - I put it in the first morning to show her, and she put it in on the second one, and that was it. I don't know what she's done with it."

Mother of Tracy (age 9) 1522211/44 p.13

Tracy's mother was kept fully occupied looking after four children on her own and she had not managed to find time to keep the diary for this study either (Section 3.7.3).

Charting progress can be a helpful way of demonstrating to the young person that they are capable of achieving dry nights (Blackwell, 1995; Butler, 1993 a,b; 1994):

MR A: Whenever a chart is being kept things have improved. As soon as there's a hands-off approach, there is no physical recording or anything like that, then the whole thing goes haywire."

Father of Anthony (age 16) 1522211/25 p.1

Both Anthony and Alison experienced many fewer wet nights during the diary keeping (Appendix XIV). Alison had found the diary keeping easy:

"MRS A: She found it very very easy. She found it great, no trouble at all. She's enjoyed it! ... It worked a lot better than the star charts. The star charts didn't work at all, but that was like she would get a reward if she managed it three days, but she couldn't do that and she didn't take part in it either. I think marking the chart yourself works because she's taking part in it too. She did it all herself."

Mother of Alison (age 9) 1522211/14 p.5

Alison's mother made two important observations. She felt that the chart had worked because Alison had taken an active part in keeping it and there had been much less pressure on Alison because the chart had not been linked to any system of tangible rewards. She was praised for simply keeping the record but she also came to see that dry nights were possible. At the end of the month the frequency of Alison's wet nights had fallen from seven to two per week and she wanted more diary forms. It is suggested that the supportive climate created by both Alison's parents had a great deal to do with Alison's success but she could have become dry during this period by chance (Section 2.2.2).

In contrast, the mothers of Martin and Tracy had had little faith in the charts and the record keeping had lasted less than a week. The parents' pivotal role in creating the climate for the young person to learn or re-learn the skill of becoming dry at night is developed further in Chapters 6 and 7.

Bedside and body worn alarms

Fourteen young people in this study had used a body worn alarm at one time or another (Table 13) and four young people were using one at the time of the study. Some parents suggested that the alarm woke everyone on the household except the child and was difficult to switch off:

"MRS A: It woke everyone in the house except Anthony! (laughter from everyone.) We used to have your cigarette lighter, trying to dry off the mechanism so that it would stop making a noise, and that caused friction - I think we had that - for how long? - a week? And that went back!...
 MR A: That wasn't a raving success!...
 SUSAN: That's the first one I remember.
 MRS A: You remember the alarm (all laugh) - we all remember the alarm!... the whole road remembers the alarm!"

Mother, father and sister of Anthony (age 16) 1522212/27 & 64 p.1

In Anthony's family the alarm had become a family joke, long remembered and used for a very short time. Anthony himself described the alarm as "very tedious". Several parents commented that the alarm had caused the young person a considerable degree of distress:

"MRS W: He became very upset at 3 a.m. because of the buzzer's noise and asked to get it taken off, which I did."

Mother of William (age 9) diary entry.

"MRS J: She refused to use the bell and pad tonight, saying it was most uncomfortable as the previous night she was frightened to sleep because of it, she wakened dry."

Mother of Jennifer (age 9) diary entry

Jennifer herself had a clear opinion of the alarm:

"JENNIFER: It's uncomfy. When you went to the toilet you had to take the whole alarm off and put it back on again. It took ages...

MOYA: So if someone suggested to you that you try it again, what would you say?

JENNIFER: Get lost!!

Jennifer (age 9) 1522212/44 p.25

William began treatment with an alarm during the study. The adverse consequences for everyone in the family were said by his mother to have changed her attitude to his bed wetting:

MRS W: I feel that our attitudes to his bed wetting had changed because of the buzzer, and it's not improved ... To me, before, it wasn't a problem, and the only reason that I did something about it was for William - it wasn't for me ... now, it's intruding on me as well. And I suppose because I'm back at university and, I'm sort of feeling that I need my sleep - and it's you know - it's irritating me ... My attitude's gone from being very laid back about William to being - well, you know, I'm getting up here every night, and I expect to see something, you know - I mean - don't get me wrong, I'm not saying it to him, but it's annoying to me now because it's intruding in my life and because we're not getting anywhere."

Mother of William (age 9) 1211/6 & 8, p.5

This is, perhaps, one of the most disturbing findings of families' experiences of an alarm. Not only had this treatment failed to bring about the desired effect, it had also changed the mother's expectations and led her to experience negative feelings where before she had felt relaxed about the bed wetting.

Some of the young people had not used an alarm. Three parents had been told by the health visitor that their child was too young to benefit from one. Certainly Martin had been distressed by this method when he had tried it when five years old, at his mother's insistence. He used the alarm for less than a week.

Few parents in this study had used a body worn alarm for any length of time because of the inconvenience that it had caused to everyone in the household, yet the results of carefully controlled clinical trials (e.g. Butler et al, 1988, 1990; Fordham and Meadow, 1989; Kaplan et al, 1989) suggest that the body worn alarm can achieve a high success rate when carefully supervised and has a considerably lower relapse rate than the use of medication alone. The experiences of the families in this study perhaps reflect health care professionals' lack of awareness of the amount of support young people and their families need with a method which requires sustained commitment from the whole family for many weeks to stand a good chance of success (Butler, 1994; Devlin and O'Cathain, 1990; Dische et al, 1983; Fordham and Meadow, 1989; Forsythe and Butler, 1989; Johnsen, 1992; Larsen et al, 1992; Meadow, 1977; Morgan, 1993).

Medication

Half the young people in this study had been prescribed medication for their bed wetting at one time or another (Table 13).

Nine young people had been prescribed Desmospray and five were taking Desmospray at the time of the study. In the cases of Roger, Ian and Simon it had certainly been associated with a dramatic fall in the number of wet nights per week (Appendix XIV) and Simon remained dry for two weeks at the time of the study when he discontinued its use. There is a growing body of evidence in support of Desmospray's efficacy and mode of action (eg. Hjälmås & Bengtsson, 1993; Meadow, 1989; Rittig et al, 1989; Stenberg & Lackgren, 1994). It had not been so successful for Peter and Sarah but it transpired that both these young people had lost faith in it as a method and only used the spray intermittently:

"MRS S: ... I said, 'you know it seems to be doing quite well, Sarah, you've not been wetting the bed, we seem to be dry quite a lot'. She said, 'it doesn't make any difference whether I take the spray or not'. I said, 'when you take the spray we seem to have had quite a few -'. But I sometimes don't take it just to see if I'll wet the bed and sometimes I don't wet the bed, so it doesn't work'."

Mother of Sarah (age 11) 1522221/7 & 8 p.4

There is an important lesson for health care professionals in this account. Young people are not merely passive recipients of advice and cannot be assumed to be complying with the treatment prescribed. They evaluate the methods that they are asked to take part in and may act on their evaluation.

When incentive charts had failed Carol had been prescribed Imipramine which she had supposedly been taking for the past year and a half. Carol did have some symptoms suggestive of an unstable bladder (Appendix XIV) which may be the reason why this medication had been prescribed, but the researcher's observation of the tablet bottle suggested that few tablets had been taken in the previous six months:

"CAROL: It worked for a wee bit and then the next minute, stopped working.

MOYA: How long did it work?

CAROL: About a couple of nights and then that was it. The medicine, the sniffer, they tablets, and that's it."

Carol (age 17) 1522222/4 p.3

Nothing that Carol had tried had had any lasting beneficial effect for her.

Peter had also been prescribed Imipramine but his mother had become concerned that he was becoming dehydrated:

"MRS P: They're just making him more thirsty. And his lips would go quite dry and I think well that's really not a good way. I'd rather he did it himself, you know his mind told him, 'don't want to wet the bed any more'. I'm a great believer in nature taking its way rather than take tablets."

Mother of Peter (age 15) 1522222/54 p.1

Martin's mother had also been concerned about her son taking medication but she had been delighted by the results:

"MRS M: I've never really looked back. It's like a magic potion - it has, from the first night, I can't believe that it could have, it's done the trick."

Mother of Martin (age 6) 1522223/1 p.1

Martin was on a reducing dose of Tryptizol and his mother's main concern was that the bed wetting would recommence when he ceased to take it. There is evidence that the beneficial effect of anti-depressants disappears when the drug is discontinued and there is increasing concern being expressed by some clinicians about the use of anti-depressant medication in children (Wille, 1994), although their use is still recommended by some psychiatrists (e.g. Ambrosini, 1993). One of the biggest

hazards is accidental poisoning if insufficient care is taken to keep the tablets out of children's reach. Many adverse side effects are also associated with their use (Wille, 1994; British National Formulary, 1995).

Complementary medicine

The parents of Anthony and Paul had tried complementary medicine in their search for a cure for the young person's bed wetting. Both had tried hypnotherapy, at the suggestion of their local GP, but without any really long-lasting success. Paul had little recollection of what had happened during the hypnotherapy but his mother was sure that it had had some positive benefits. Hypnotherapy has been found to be an effective treatment in some cases (Edwards and van der Spuy, 1985; French, 1992; Simpson, 1991).

Anthony's family recollected the herbal treatment and their involvement in it vividly:

"MRS A: We had to eat pumpkin seeds ...

SUSAN: Anthony had to do it, and we would say 'we'll eat one if you eat some'.

MRS A: So we put them on his breakfast cereal, we tried to cook with them, we tried sweets.

MR A: Pumpkin cakes! (laughs)

MRS A: We tried everything - even today we would go up and in a drawer, in a very obscure place upstairs, we open it up and there are pumpkin seeds and Anthony is now 16! (all laugh). He would say he'd had them, he'd put them down his trousers, they were everywhere ... they're revolting things - so we gave up on that one!"

Mother, father, and sister of Anthony (age 16) 1522132/10 p.1

It would seem that Anthony was less optimistic about this treatment than the rest of the family and had only participated in it half-heartedly.

Anthony's family, like the families of Peter (age 15), Paul (age 13) and Ian (age 13), had made a concerted effort to help the young person to become dry over many years, yet without the reward of a successful outcome. The consequences for families of running out of ideas are described in Section 5.6.3.

5.6.2 Parents' evaluation of help received from health care professionals

Parents clearly had opinions about the help that they had received from health care professionals and articulated these opinions in a quite unsolicited way, for the most part. The parents' comments have important implications for practice (Chapter 7).

Questioning the overall attitude and approach of health care professionals

The attitude of some health care professionals had clearly upset some parents:

"MRS L: It was their attitude all the way through. It was students and one sort of head doctor - 'it's all in her brain, all in her mind'. They went to put dye in her, but she wouldn't sit long enough for them to get a good picture so - I felt they were awful. Any time I mentioned about that she wet maybe two or three times a night, they said, 'it's not smelly anyway' and I said, 'It is!'."

Mother of Lisa (age 4) 1522211/6 p.14

The medical students had discounted the views of Lisa's mother about the social consequences of bed wetting, such as the smell of the urine, and had embarrassed her with persistent questioning about the sleeping arrangements in the house. This mother was made to feel that she was to blame.

Attempting to carry out invasive investigations on a two and a half year old was almost doomed to failure as it is unrealistic to expect a child of this age to be able to co-operate. Such attempts could also lead a child to become frightened of further investigations. The students had been angry because Lisa wouldn't sit still. This particular consultation had obviously been unsatisfactory for everyone.

The mothers of Lisa and Sarah had felt that they were being personally blamed for their daughters' bed wetting.

"MRS S: ... they tend to - they look for a scapegoat. They do do it. You get it the whole time - I get it from Dr D (the paediatrician) even. 'Well, you know, she lives in a high stress house and ...' and I say, 'I don't think it's really that high stressed, is it?' 'Yes, it is.'"

Mother of Sarah (age 11) 611/36, 37 & 38 p.9/10

Four mothers questioned the approach that health care professionals had adopted with their children. In contrast to the excellent relationship that the whole family had with their GP, Jennifer's mother felt that the doctor who had seen her daughter about the bed wetting had not managed to establish a good relationship with her during the consultation:

"MRS J Jennifer didn't like her and I felt we got off on the wrong foot. I felt Jennifer wasn't at ease with her. Jennifer wouldn't speak to her ...I feel, well I've had four kids and been on the PTA (Parent Teachers' Association) for years and worked with kids and helped with kids, you've got to get on with the kids, relate to them or they clam up and I feel that's what Jennifer was doing."

Mother of Jennifer (age 9) 152415/19 p.2

Because of the embarrassment and shame that most young people feel about their bed wetting (Section 6.4.2) Jennifer's reluctance to talk with a stranger about it is not surprising. Such

conversations require to be conducted with considerable tact and understanding on the part of the therapist. Jennifer was much more relaxed and talkative when taking part in this study but the conversations were taking place in her own home and at a pace set by the family.

The main concern of Gary's mother was that the clinical psychologist had been talking to the wrong person. She had at first appreciated having someone to talk to about her own problems but in the end she described the sessions as "a waste of time". She said that she would only turn to this source of help in the future if Gary was involved too:

"MRS G: It's no' me that's got the problem - it's Gary. Fair enough, it's part o' my problem, I've got to learn how to deal with it, and how to deal wi' Gary, but I feel that I know what I'm daein' - but I just feel that Gary does need help on that side. I feel Gary needs to learn to get a lot of his emotions oot - because I feel Gary keeps too much in himself - he's quite a reserved wee person, if you know what I mean."

Mother of Gary (age 5) 152415/6 p.3

It would seem that in the end neither her needs nor Gary's needs were perceived to have been met.

Anthony's parents described how he had become more reliably dry while keeping a chart but that a visit to see the paediatrician had set back progress. Instead of seeing the consultant Anthony had been seen by the Registrar:

"MRS A: I remember when we stopped the charts. I tell you what stopped the charts! We went to a clinic and it wasn't Dr. D (paediatrician) it was one of his - one of the ladies - and she said to Anthony ..I'll see you in six weeks time - and you will be dry - I know you'll be dry'... So we did the star charts, and we wet, and we wet, and were wet, and as soon as he was dry, he didn't want to go any more. That was a very significant part, I remember that, and we did ask and it was 'because that lady said I'd be dry, and I'm not'. So the star chart was a gonner."

Mother of Anthony (age 16) 1522211/70 p.1

Anthony himself recalled his disappointment at being told that he would be dry at certain ages and not finding that he was dry when he reached these ages. It could be that the pressure caused by other people's unrealistic expectations, and the failure to achieve goals set by others had actually set back progress in Anthony's case.

"They've no more ideas"

Six mothers felt that the health care professionals that they had approached had run out of ideas of ways to help them and had left them, effectively, to cope alone:

"MRS A: We always felt there isn't any real help for a bed wetter, there is nothing. I mean the health visitors give you advice and that, but none of it works."

Mother of Alison (age 9) 1524113/23 p.1

"MRS J: She (the doctor) more or less said that it was just one of these things. She said something about getting her urine tested which has never happened. She didn't say would I go and take her or whatever. You were just sort of left."

Mother of Jennifer (age 9) 1524113/20 p.1

Other parents commented on the lack of follow-up after a consultation.

Three mothers felt that they were simply being re-offered methods which had not worked in the past:

"MRS P: You'd go to your GP and it was always just 'well, there's various things you can do, there's buzzers, there's this, there's that'. Well, we've been through all that, and that was it."

Mother of Peter (age 15) 152412/23 p.1

Peter's mother had had the idea of forming a self-help group in case any other mothers had ideas to share which might help her son.

Tracy's mother was unimpressed when the clinical psychologist suggested trying charts again:

"MRS T: She just gave her a star chart. I said, 'but the star chart's no use'. I says, 'she's been on all that'. Then if that doesnae work they were going to put her on a bed alarm, but the bed alarm was no use either... Twice we tried the bed alarm."

Mother of Tracy (age 9) 1522211/26 p.14

Some parents had felt that a client-centred approach was merely putting the responsibility back on to them when they did not have enough knowledge of the causes of bed wetting and the treatment options to make an informed decision:

"MRS S: ... people are talking to you and saying, 'what do you see is the way forward?' as Miss A (the health visitor) would say to me ... 'We've tried this and we've tried this, what do you think?' You don't know what's on the market, so I suggest something that we've tried before. 'We know that, but what do you think is next?' Because you haven't got a little box that you can say 'We know why it started'. You have no point to go from. You don't know where to go. You're going into a blind alley as far as you're concerned."

Mother of Sarah (age 11) 1524110/100 p.1

Eight mothers expressed the view that their health visitor had been supportive in general, but tended to avoid raising the subject of the bed wetting:

"MOYA: B (health visitor) came to see you last week, and did she have any more ideas?"

MRS G: No, B doesnae - I telt B that he's still wettin' the bed and that but I think B's just - I don't know - I feel that B's not really - it's no' that she's no' interested, but she's never asked me - like what dae I dae about it to try new things - she's never really spoke about it."

Mother of Gary (age 5) 1524116/7 p.1

Gary's health visitor was currently visiting the family to support the mother in the care of her baby who was only six weeks old. She was fully aware of Gary's bed wetting but she did not know how to help the mother to deal with it.

It became apparent from the parents' comments that many health care professionals were at a loss as to how to proceed when certain standard methods had failed to achieve the desired outcome. Some health care professionals were said to have lost interest, others attempted to encourage the family to re-try methods which the family had already lost faith in. This is reminiscent of many parents' own response of falling back on a long practised habit when faced with an ongoing challenge and insufficient responses in their repertoire to meet it (Section 5.5).

5.6.3 What happens when everyone runs out of ideas

"MOYA: And what happens when you run out of ideas?

MRS A: (laughter) Do most people try everything?

MR A: The answer is brandy! (laughter)

MRS A: Valium. Endless cups of Earl Grey tea for me and brandy and lemonade for John. It is, I think, enuresis ... has a devastating effect on the family as a whole. For me, it is more perhaps because I'm more sensitive. It stops so many things."

Mother and father of Anthony (age 16) 15216/90 p.1

The pervasive and far-reaching consequences of bed wetting for the individual and the family are described throughout this chapter. When analysing parents' feelings about the young people's bed wetting, parents' frustration and feelings of helplessness were recurring themes. For many parents their inability to help the young person was regarded as the worst thing about the bed wetting:

"MRS A: You feel helpless, that's exactly it, you don't know what to do for the best for her. She's wetting the bed, you try everything you get suggested to you, nothing's worked and still the bed wetting goes on."

Mother of Alison (age 9) 15216/30 p.2

An unexpected finding was that parents could come to the stage of feeling that they had run out of options when the young person was as young as four years old:

"MOYA: So what are you thinking that you might do next ...?"

MR L: Just going to leave her to see if she maybe grows out of it. It's a' you can do. You know what I mean? We've tried everything."

Father of Lisa (age 4) 15216/7 p.3

Families' experiences of methods suggested by health care professionals were such that many families had come to believe that health care professionals had no more helpful responses in their repertoire than the families had themselves (Section 5.6.2). Sarah's mother went so far as to suggest that some health care professionals plucked ideas out of the air:

"MRS S: I try anything that anyone will suggest to me, but I think they have run out of options ... it's a major puzzle ... (A) specialist thought it might be because she was ultra brainy. I don't accept that. I think that's just - I don't think they know so they make something up!" (laughs)

Mother of Sarah (age 11) 15216/10 & 100 p.2

Several parents commented on their reluctance to share the "shameful" family secret that their child wet the bed when the opportunity presented itself, for instance at a pre-school check. Having been reluctant to involve health care professionals in the first place some parents felt that they were regarded as a nuisance if they went back to health care professionals when their first suggestions failed:

"MRS M: I've been to the doctor that many times and it's all through this ... And they think I'm like a hypochondriac! It's just been like trying to get help from somebody because you don't know what to do. I know now they say it's common, but you don't realise it's common till it happens to you. No, you don't. I'm sure there are loads and loads, but you can understand, I've kept it hidden for his sake. And a bit for my sake, because you feel you're a bit of a failure - what have you done wrong?"

Mother of Martin (age 6) 15216/8 p.1

Many families come to a point when they feel that there is no more that anyone can do. Those parents who had wet the bed themselves or had shared a household with a bed wetting sibling were often the most philosophical in that they believed, for the most part, that the young person would one day be dry although they did not know when or how this would happen (Section 6.3.2). This gave them hope for the future. These families were also most likely to stop looking for a solution as they had come to believe that their interventions were unlikely to influence the outcome.

The parents of some of the older participants in this study, such as Carol (age 17), Anthony (age 16), Peter (age 15) and Roger (age 14) said that they felt that they had come to a point where they

had done all they could for the young person and had tried to hand the responsibility for dealing with the situation to them:

"MRS P: I don't know ... what line I should now take. We've tried it one way and it's not working, we've ruled out the psychologist, we've ruled out being lazy and the placebos ... whether I just take a back seat now and say, 'well we've given you all the help available, and it's not my problem any more' - you know - and just let him get on with it ..."

Mother of Peter (age 15) 15216/26 & 34 p.2

What of the young people themselves upon whom responsibility for dealing with the situation may ultimately be devolved? Do they have any more ideas about how to achieve dry nights than their parents and health care professionals have? This study suggests that they do not (Section 6.4.1). Few of the young people in this study had any ideas about why they wet the bed or when the bed wetting would stop.

Having explored every avenue that they believe is open to them it is not surprising that most parents and young people give up searching for a solution. Action occurs at the intersection of intention and opportunity (Broderick, 1993). Without a viable course of action there is no opportunity for taking action to achieve the goal of the young person becoming reliably dry at night and the family is left to cope with the consequences of bed wetting.

In the absence of much constructive help from health care professionals, who may even avoid becoming involved in a situation where they feel that they have nothing new to offer, families are often effectively left to cope alone.

5.7 Summary

In most families in the present study the management of bed wetting was seen by both parents as a natural extension of the mother's child care role. Most mothers acted as the "orchestrator" of events, co-ordinating the activities of people within the household and those outwith it, such as wider family, friends and health care professionals. Fathers were not, however, without influence and some had become directly involved in the day to day practicalities, either at the request of the mother or because the mother was unavailable, at times, because of paid employment or illness.

Although health care professionals' intentions to be helpful were rarely questioned most parents had come to believe, from experience, that these professionals had little help to offer to resolve the problem, irrespective of the age of the young person. Most parents perceived themselves to be and were, for the most part, left to cope with the situation by themselves.

Two thirds of the young people in this study had been punished, at some time, for wetting the bed and many had to face the censure of their siblings from day to day. Maintaining secrecy outwith the family was high on most young people's agenda, motivated, it seemed, by their fear of disapproval and rejection by others for their lack of ability to perform an "easy" task usually achieved by children of three to four years of age. Some young people denied that even their closest friends knew about the bed wetting. Many were anxious about staying away from home or having friends to stay for fear that their secret would be discovered.

The effects of one young person's bed wetting were not confined to the young person and the principal carer but could impinge upon everyone living within the household, affecting relationships within the family and the nature of the family's social contacts with wider family and friends.

However, not all families appeared to be equally concerned about the bedwetting. The negative and pervasive consequences perceived by some parents were at one extreme but important end of a continuum of experience. At the other end of the continuum there were a few parents who regarded the family as unaffected or only minimally affected by the bed wetting. Most families seemed to be at a point somewhere between these two extremes.

The nature, antecedents and consequences of parents' and young people's attitudes towards bed wetting are explored in the next chapter. Understanding the beliefs underpinning the perspectives brought by different family members to situations related to bed wetting helps to explain the differences between family members in their tolerance of it and whether or not the bed wetting is appraised, both individually and collectively, as a cause for concern.

**CHAPTER 6: THEORY DEVELOPMENT - THE RELATIONSHIP BETWEEN
BELIEFS, FEELINGS AND BEHAVIOUR, IN THE CONTEXT OF
THE FAMILY'S EXPERIENCE OF BED WETTING**

6.0 Introduction

"Family therapists are keenly aware that understanding client metaphors is a key to understanding how client realities are constructed. Client metaphors provide the context of a client family's problems, reflect and create client realities, and limit the ways in which the family comes to terms with its problems ... Family therapists are no different from their clients in that metaphors guide and limit their thinking. The theoretical metaphors used by family therapists contextualise, reflect, and create their therapeutic realities and limit the ways in which they understand client words and actions and come to terms with client problems. Any way of thinking about anything can be useful, but it is always limiting."

Rosenblatt (1994) p.14

Social science draws heavily on metaphors to gain an understanding of and to organise thinking about phenomena, for example family systems theory draws on metaphors from cybernetics (Section 2.3.2). In nursing the concept of "family systems nursing" is being developed (Wright and Leahey, 1994). This conceptualisation draws on systems theory and cybernetics (Wright and Leahey, 1993).

In his book *Metaphors of Family Systems Theory*, quoted above, Rosenblatt describes the pivotal importance of therapists understanding the ways in which their clients make sense of their world if interventions are to be effective. He suggests that clients and their therapists may be seeing situations very differently because they are viewing situations with the help of different conceptual frameworks.

The focus of this chapter is on understanding how parents and young people view bed wetting and the relationship between family members' beliefs, feelings and behaviour as they interact with one another from day to day.

Section 6.1 sets the scene by describing the nature and purposes of theory. Section 6.2 describes the final stages of theory generation in this study, including the identification of the core concept and the

development of a model to show the possible relationship between related concepts. Parent's and young people's beliefs about the causes of bed wetting and their attitudes towards it are described in Sections 6.3 and 6.4. The social origins of these beliefs and attitudes are explored in Section 6.5. The antecedents and consequences of perceived helplessness are described in Section 6.6, which concludes with a conceptual analysis of perceived control.

6.1 The nature and purposes of theory

The nature and purposes of theory are explored in this section as a prelude to a brief description of the final stages of theory generation in this study. It is argued that concepts, hypotheses and theories are not found ready-made in nature but are constructed. Theories are regarded as tools which can help the researcher and others, to gain a better understanding of the patterning and predictability of the social world.

Gaining an understanding of theory is made difficult by the lack of agreement in the literature about what theory is and what it is for (Lincoln and Guba, 1985) and the absence of more than passing reference to theory in many authoritative works on research methodology, including Denzin and Lincoln's (1994) *Handbook of Qualitative Research*, as noted by Strauss (1995).

A number of texts such as Marshall and Rossman (1995), Tesch (1990) and Gilbert (1993), describe the role of theory in providing the assumptions which guide research design. However with the exception, perhaps, of grounded theory (Section 3.9.4) there is relatively little discussion in the literature on the nature of theory as an outcome of the research process.

Some definitions of theory, culled from texts on research methodology, are given in Table 14. In many texts on research methodology no definition of theory is included. A review of the definitions summarised in Table 14 suggests that theories are "explanations" of phenomena. Other purposes of theory can be to systematise, to uncover, and to predict (Lincoln and Guba, 1985).

The ultimate purpose of explanation and prediction, as described by researchers adopting the positivist paradigm (Table 1), is usually control.

TABLE 14 Some definitions of "theory"

| <u>Source</u> | <u>Definition</u> |
|----------------------------------|--|
| Holm and Llewellyn (1986) p. 273 | An abstract generalization that presents a systematic explanation about the relationships among phenomena. A series of principles, or propositions, regarding the inter-relationships among concepts |
| Polit and Hungler (1989) p. 403 | An abstract generalization that presents a systematic explanation about the relationships among phenomena |
| Silverman (1993) p. 1 | A set of explanatory concepts |
| Strauss and Corbin (1994) p. 279 | Theories are interpretations made from given perspectives as adopted or researched by researchers |
| Vogt (1993) p. 232 | A statement or group of statements about how some part of the world works - frequently explaining relations among phenomena |

For researchers who adopt the naturalist paradigm, prediction and control are not seen as inevitable or necessarily desirable outcomes. The emphasis is on organising data about a phenomenon in a form which reflects the perspective of the study's participants so that others may glimpse and vicariously gain insights into the participants' lived experience. The insights gained and clearly explained in a theory can facilitate empathy and prevent misunderstandings between clients and their therapists in similar situations. Explanation, rather than prediction and control was seen as the primary purpose of theory development in this study although a tentative theory has emerged which may prove to be predictive of a family's engagement in treatment (Chapter 7).

O'Brien (1993, p.11) likens theory to a kaleidoscope:

"The components of the world being investigated combine and recombine into new patterns as they are viewed through different theoretical perspectives [the different lenses of the kaleidoscope]. Different theories bring different aspects of the world into view ..."

He suggests that the way in which a phenomenon is observed is instrumental in determining which aspects of it are seen. It follows that looking at a phenomenon from one perspective will highlight some aspects and may obscure others. O'Brien's metaphor illustrates the multiplicity of realities in the natural world which cannot *ipso facto* all be seen at once.

Like O'Brien, Morse (1992a, p.4) sees theories as tools constructed by the researcher to help to give meaning to data:

"They (theories) are merely abstractions, conjectures, and organisations of reality ..."

Theories are not "facts" and they can be modified in the light of new data.

The outcome of much qualitative research is a descriptive account of a phenomenon as given in this study in Chapter 5. Is there theory in description? Van Maanen (1983b, p.9) suggests that the descriptions of the social world which result when researchers use qualitative methods are like "maps" of the territory that the researcher has chosen to study, which can be used to guide others through that territory. However, he makes the following cautionary point:

"... the map cannot be considered the territory simply because the map is a reflexive product of the map-maker's invention..."

Strauss (1995) argues that it is not possible to describe anything without implicit theory, that is some degree of speculation or interpretation about what it is that is being described. He also suggests that there are implicit concepts embedded in the very language of description. However, he argues that description does not constitute explicit theory of itself.

In this study theory is defined as a type of explanation which involves conceptualisation and the coherent linking of concepts (Sections 3.2.3 and 3.9.4). The relationships between parents' and young peoples' beliefs, feelings and behaviour in the context of bed wetting are explored in this chapter. The cognitive basis and the consequences of seven patterns of parental response to the young person's bed wetting and seven patterns of response displayed by the young people themselves are described in Sections 6.3.2 and 6.4.2. The social origins of these beliefs and attitudes are explored in Section 6.5.

The data strongly suggest that five conditions need to be fulfilled for the young person to have the best chance of becoming reliably dry at night, using conventional treatment methods. These conditions are described in Chapter 7, where suggestions are made about ways of further testing the tentative theory proposed there.

6.2 The final stages of theory generation and testing in this study

6.2.0 Introduction

"It is not to see something first, but to establish solid connections between the previously known and the hitherto unknown that constitutes the essence of specific discovery".

Selye (1956) p.6

The techniques used to facilitate the complex and creative process of theory generation in this study, including the use of memos and logic diagrams and the construction of a hierarchical indexing system to organise data on a conceptual level, are described in Section 3.9. The final stage of theory development is synthesis, that is the integration of data into an explanatory framework at the most abstract conceptual level.

The identification of the core concept of "perceived control" is described in Section 6.2.1. A conceptual model developed to explore the relationships between beliefs, feelings and behaviour is described in Section 6.2.2.

6.2.1 The identification of the core concept

Theory generation is facilitated by the identification of the core concept, that is the central phenomenon around which all, or the great majority of the other concepts and categories can be integrated.

The phenomenon of "perceived helplessness" was identified as a category early in this study. Individuals who perceived themselves (or others) to be helpless believed that they (or others) were unable to influence the situation, that is they believed that the outcome was not contingent on their (or others') efforts. During analysis it became apparent that perceived helplessness was a widespread phenomenon, linked with many negative emotions in that:

- 1) almost all the young people in this study who wet the bed perceived themselves to be helpless to stop it and felt ashamed that they could not achieve an "easy" task that most 3-year olds could accomplish (Section 5.3)
- 2) all the parents spoken to had perceived themselves to be helpless to control the situation at one time or another and many said that they had experienced feelings of hopelessness and despair at those times when they had felt most helpless (Sections 5.2, 5.4, 5.5 and 5.6)
- 3) most parents had come to believe, from experience, that the health care professionals to whom they had turned for help were also helpless to influence the situation in a therapeutic way (Section 5.6.2).

Perceived helplessness appeared in many guises in the data and was at first identified as the central phenomenon or core concept in this study.

Conceptual analysis of the phenomenon of perceived helplessness involved going back to the data and asking many questions, such as:

- a) what are the conditions that lead individuals to believe that they are helpless?
- b) how stable is perceived helplessness over time?
- c) how do parents and young people respond to a situation when they believe that they are helpless to influence it?
- d) is their response affected by any intervening conditions?
- e) how do young people and their parents interpret and respond to each other's behaviour when either or both believe themselves to be helpless?
- f) what are the consequences of perceived helplessness for the young people and their parents?

While perceived helplessness was confirmed as being a commonly experienced phenomenon, it was found that some parents who believed themselves to be helpless to influence the situation at the present time nevertheless felt optimistic that their child would one day be dry, while others were pessimistic that the situation would ever be resolved. Optimism about the future seemed to be a particularly important factor in influencing the individual's present feelings about the bed wetting.

Re-evaluation of the concept of perceived helplessness suggested that the concept was transcended by the concept of "perceived control". This concept helped to explain the variety in the data and was found to be of central importance both for young people and their parents. The relational aspects of perceived control, that is how much control individuals perceived others to have over the situation, was found to be particularly important.

The concept of perceived control features in many ways in Sections 6.3 - 6.6 which describe parents and young people's beliefs about bed wetting and the consequences of these beliefs when translated into action.

It is shown that perceived helplessness is for the most part situation-specific, that is specific to situations relating to bed wetting and is a more stable experience for young people than for their

parents. Many parents believe that they could control the situation if they could find the means. For the minority of parents and young people, perceived helplessness appeared to be a more global experience affecting other aspects of daily living.

A concept analysis of perceived control is given in Section 6.6.2, where this study's findings are briefly compared with the findings from the vast body of research on perceived control conducted in other situations.

6.2.2 The development of a conceptual model to explore the relationships between beliefs, feelings and behaviour

6.2.2.0 Introduction

In the present study the development of a conceptual model acted as the spring-board for the final stages of theory development.

The terms "conceptual framework", "conceptual model", and "model" are often used synonymously in the research literature and are used synonymously here. Rosenblatt (1994, p.15-16) describes conceptual frameworks as:

"... an overview of a domain that includes a general focus on the domain; a sensitization to certain issues, concepts ...; concept definitions ... and general ideas about relations among concepts ... (they) lack integrated, tightly constructed, phenomena-comprehensive propositions."

They represent a less formal and less well developed mechanism for organising concepts of relevance to a common theme than is provided by theory. Polit and Hungler (1989) suggest that this in no way diminishes their importance or value in the research process in clarifying concepts and their associations, in facilitating the generation of hypotheses to be tested and in revealing other, related areas for inquiry.

From the earliest analysis of data from this study certain beliefs appeared to be potent determinants and predictors of the attitude and behaviour of the young people who wet the bed and their parents. These beliefs included beliefs about the cause of the bed wetting and beliefs about the individual's

control over it. Other beliefs which seemed to be influencing the nature of parents' actions including their beliefs about what a "good" parent "should" do and their beliefs about the young person more generally, both as an individual and as a member of the family.

The conceptual model, illustrated at Figure 14, was developed to facilitate an understanding of the relationship and interplay between beliefs, feelings and behaviour at an interactional level. The elements of the model are described below.

6.2.2.1 Some components of the model and their temporal relationship

The related concepts of beliefs, feelings and behaviour, which constitute the principal components of the model, are first defined and discussed in general terms.

The nature of beliefs

The term "belief" is rarely defined in the research literature. When concluding a conceptual analysis of "beliefs" in the context of parent-child interactions, Sigel (1985) noted that there was no accepted psychological definition of belief. The term is noticeably absent from many recent textbooks of psychology, appearing neither in the glossary nor in the index. Perhaps this is because "belief" is a term so commonly used in everyday speech that its meaning is taken for granted, yet it is a term which incorporates many subtleties of meaning.

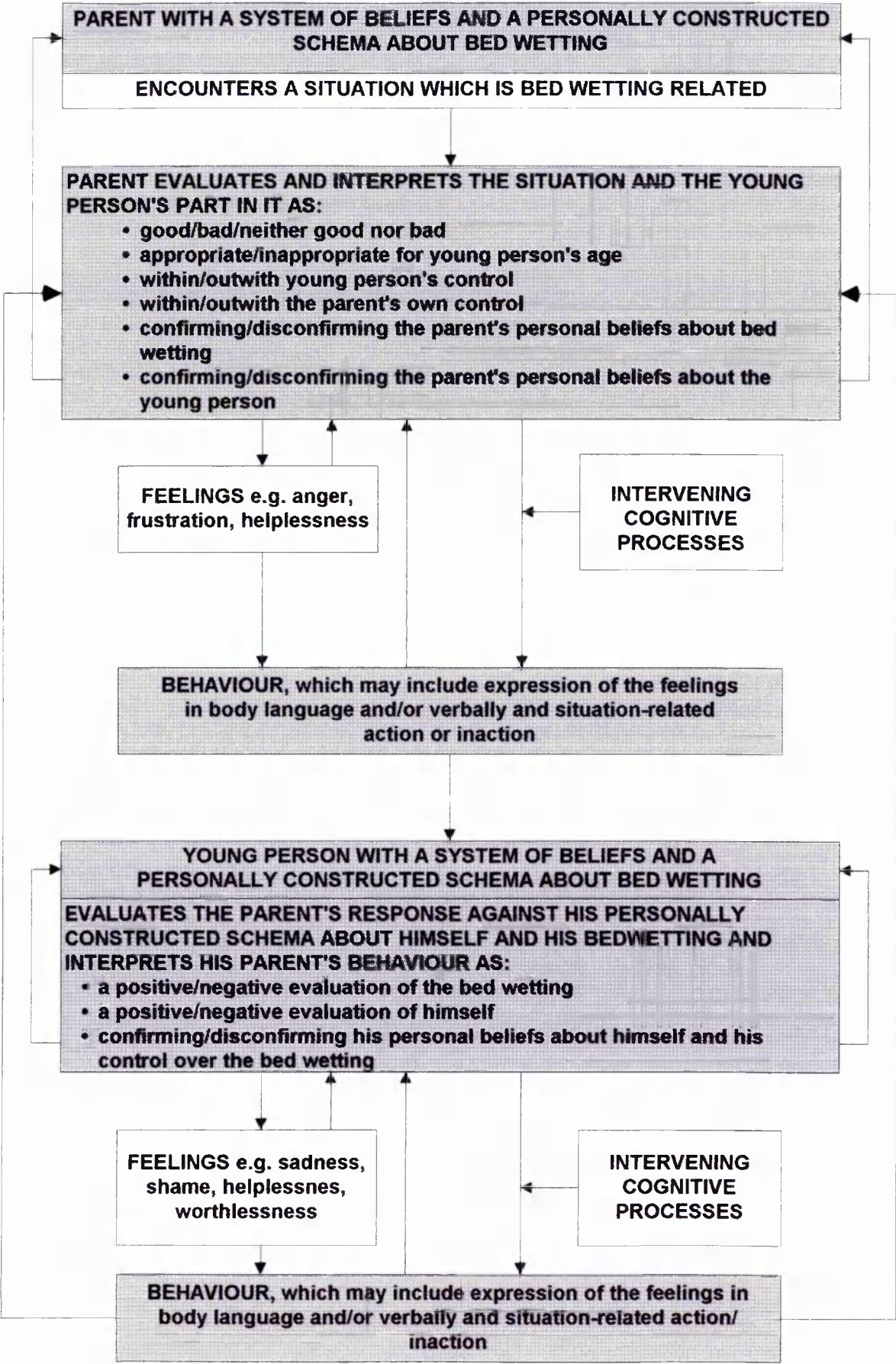
"Belief" is defined by Hewstone et al (1994, p.445) as:

"Opinion held about an attitude object, i.e. the information, thought or knowledge one has about some person, object or issue".

A detailed philosophical discussion of the inter-relatedness of the concepts of belief, knowledge and truth is beyond the scope of this thesis but a review of the work of Lincoln and Guba (1985), Harvey (1990), Root (1993) and Schwandt (1994) suggests that beliefs are constructs of reality which are particular to the individual. These authors suggest that beliefs are knowledge in that the individual "knows" what he or she holds to be true. Belief is defined in The Chambers Dictionary (1994, p.152) as:

"Conviction of the truth of anything; faith; confidence or trust in a person, etc; an opinion or doctrine believed; intuition, natural judgement ..."

FIGURE 14 A conceptual model of the sequence of events as a parent and a young person interpret and respond to each other's behaviour during an interaction relating to bed wetting



This definition implies that not all beliefs are based on evidence but may involve acceptance of an idea, perhaps put forward by a credible person, as an act of faith.

Beliefs may be based on the received wisdom of other authoritative figures such as teachers or parents, or health care professionals, which may or may not reflect the wisdom of the prevailing culture, or they may come from direct experience. Beliefs are usually a synthesis of personal knowledge gained from several sources credible to the individual. Beliefs can incorporate knowledge in the empirical sense of verifiable observations but not all beliefs are or can be based on evidence and not all beliefs are conscious. In this study beliefs are defined as: convictions of the truth of something. They are regarded as personal constructions of reality created by individuals to help them to make sense of their world. Beliefs can vary in their specificity. Some are situation-specific, others are more global.

The organisation of beliefs into schemata

"Social cognition" is defined by Baron and Byrne (1994, p.125) as:

"The manner in which individuals interpret, analyze, remember, and use information about the social world."

A key finding of research into social cognition is that an individual's thoughts about the social world are not a mixture of random ideas, knowledge and beliefs. On the contrary Shore (1991) and others suggest that information and knowledge, acquired through experience, are organised into "schemata".

Baron and Byrne (1994, p.121) described schemata as "mental scaffolds" that hold and organise information. Their importance lies in the fact that once they are formed they exert a powerful influence on the aspects of the social world that the individual attends to, the information entered into memory (usually information consistent with the relevant schema) and the information that is later retrieved from memory. Schemata usually include an affective component, that is an emotional element, which arises from a cognitive appraisal of the situation. Baron and Byrne (1994, p.125) define schemata as:

"Organized collections of beliefs and feelings about some aspect of the world ... providing structure for the interpretation and organization of new information we encounter."

Schemata are rather like the conceptual frameworks and theories used by researchers to help them to make sense of their world (Section 6.1). They may play a key role in individuals' understanding of others and themselves. Schemata have been implicated in stereotyping and prejudice. Once an individual has acquired a cognitive framework or schema about some social group based for example on an individual's race, gender, sexual orientation or religion, he or she tends to notice information that fits readily into the framework and to remember facts that are consistent with it more readily than facts that are not. As a result the stereotype can become self-confirming. Attitudes can function as schemata (Hewstone et al, 1994). They have a cognitive, an emotional and a behavioural component (Section 6.3.2). Prejudice is an example of an attitude which leads those who hold it to reject the members of some group, based on certain beliefs and expectations about them.

Schemata may be a convenient form of shorthand to help individuals to make sense of a complex social world but they are generalisations and the inaccuracy of the inferences that sometimes result from the holding of a particular schema can have far-reaching social consequences.

Hewstone and Antaki (1994) suggest that there are still issues relating to schemata that require theoretical and empirical attention. Schemata have proved to be difficult to demonstrate. They conclude:

"All we can say, at present, is that people act *as if* they use schemata ..."

Hewstone and Antaki (1994, p.118)

They also suggest that researchers in this field have lost sight of the importance of discovering more about the contents of schemata. So far the emphasis has been on uncovering the processes whereby schemata are used.

Based on the researcher's observations during this study it is proposed that parents and young people develop schemata about bed wetting. Before turning to the literature to see whether this concept existed, the researcher had thought of schemata as "personal theories" about a topic or situation frequently encountered and consistently held by individuals over prolonged periods of time to help them to make sense of their world.

The components of the schemata that appear to be particularly important as determinants of the individuals' attitudes and behaviour are described in Sections 6.3.2 and 6.4.2. Most are related to perceived control and the perceived appropriateness of the young person's behaviour for his or her age.

The relationship between beliefs and behaviour

Sigel (1985, p.346) describes beliefs as important "psychological guides" to action. He suggests that the absence of a universally accepted definition of belief should not discourage researchers from pursuing an intuitively reasonable perspective, namely:

"... much of what we do and how we do it, and the social, political or psychological positions we take, are ... related to what we believe about various aspects of social reality and our place in it."

Sigel (1985, p.369)

However plausible the idea is that there is a connection between belief and behaviour, demonstrating a relationship between parents' beliefs, their behaviour and the outcomes for children has not proved to be easy in practice (e.g. Dallos, 1995; Murphey, 1992). Similarly it has not proved easy to show a strong relationship between beliefs and behaviour in research relating to health promotion (e.g. Butterfield, 1990; Bunton et al, 1991). It is now recognised that many factors can intervene to modify the translation of beliefs into behaviour including other competing beliefs and personal priorities (Stahlberg and Frey, 1994).

The nature of feelings

Social scientists use an array of terms for "feelings" such as "emotion" and "affect". The terms can be used synonymously. Except when referring to research literature, the term "feelings" is used in this thesis because it is the term most widely used by lay people in relation to their emotions and was the term used by the researcher in conversations with family members of all ages.

The term "emotion" is much more commonly defined and described in the literature on a conceptual level than the term "belief". Bernstein et al (1991, p.A-19) define emotion as:

"An experience that is felt as happening to the self, is generated, in part, by the cognitive appraisal of a situation and is accompanied by both learned and reflexive physical responses."

These authors have identified six features of emotions:

- **emotions are experiences** - that is they are of themselves neither overt behaviours nor specific thoughts
- **emotions are passions not actions** - that is they happen to or are suffered by the self, they are not consciously initiated by the self
- **emotions can be positive or negative** - positive emotions are desirable to the self, negative emotions are not desired by the self
- **emotions vary in intensity** - using temperature as a metaphor emotions can be described using such adjectives as cool, lukewarm, and hot
- **emotions arise, in part, from a cognitive appraisal of a situation** - emotions depend on the individual's interpretation of the situation, they are triggered by the thinking self but are also experienced as happening to the self
- **emotions are accompanied by physiological and learned responses** - some of the responses are reflexive, such as an increased heart rate, and some are learned.

Throughout this study many negative emotions are described together with the contexts in which they arise. These negative emotions include anger, shame and helplessness.

The relationship between feelings and behaviour

A review of the debate in the psychological literature about the relationship between emotion and behaviour is given among others by Ford (1992), Lazarus (1991), Skinner (1995) and Weiner (1992). Ford (1992) describes three components of emotion, namely:

- **the neural-psychological** - that is the general subjective experience of the emotion
- **the physiological** - which he describes as a supporting pattern of biological processes, and
- **the transactional** - which he describes as a pattern of motor and communicative actions designed to facilitate goal attainment.

He suggests that emotions provide a potent mechanism for regulating behaviour in the short term because affective experience has an immediacy to it that is hard for the individual to ignore. He also suggests that while emotions may seem to be ephemeral there is a growing belief among some

psychologists that emotions may be at least as influential as cognitive processes as determinants of enduring patterns of behaviour, in the longer term.

While it may be that the transactional components of emotions can be and are consciously suppressed by some parents some of the time and are therefore effectively "hidden" from view, it is suggested that the visible manifestations of a parent's first feelings on encountering a situation related to bed wetting are usually all too easy for anyone in the vicinity to see, including the young person whose behaviour is the subject of those feelings (Section 6.5.2).

In the present study feelings were at first envisaged as being temporally situated between beliefs and behaviour but the situation may be less clear cut than this, as is described below.

The relationship between beliefs, feelings and behaviour

Figure 14 (p.196) shows the tentative relationship between beliefs, feelings and behaviour. It has as its origins a logic diagram which resulted from the researcher's first attempts to establish the sequence of events when a parent and a young person interacted on a "wet" morning (Figure 27, Section 6.5.3).

The behaviour which reflects the direct expression of feelings may be of separate origin from, if co-occurrent with conscious actions, which may be modulated by many intervening cognitive processes. Weiner (1992) suggests three possible temporal arrangements for thoughts, feelings and behaviour. These arrangements are illustrated in Figure 15. This researcher's conceptualisation of the situation allows that thoughts may be directly influenced by the experience of feelings, which are themselves evaluated as happening to the self, perhaps leading to reinforcement of or an alteration of the parent's behaviour (Figure 16). It is envisaged that the parent evaluates his or her own behaviour and actions as these are in progress (Figure 16) as well as evaluating the observable consequences of these actions (Figure 14).

FIGURE 15 Some possible relationships between thoughts, feelings, and behaviour
(from Weiner, 1992, p.363)

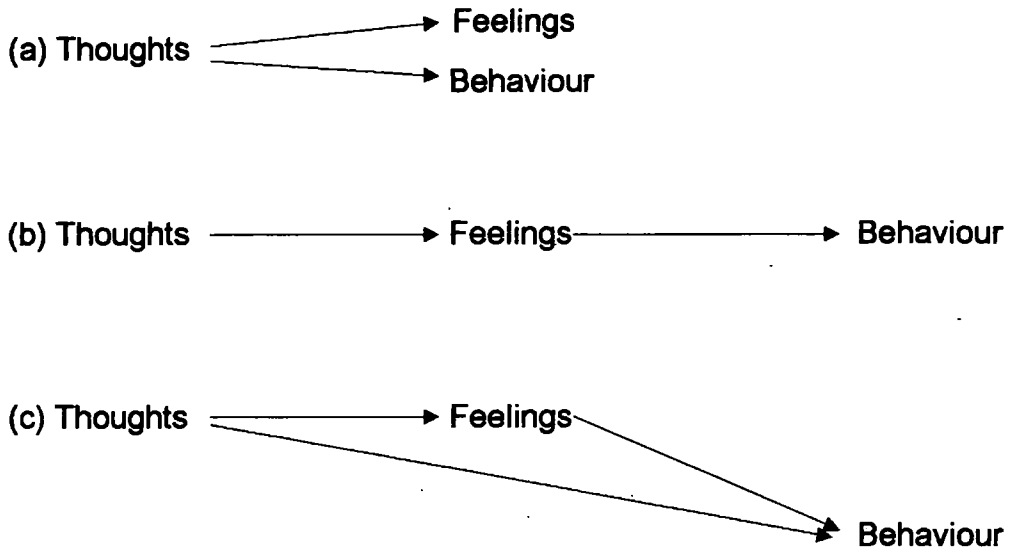
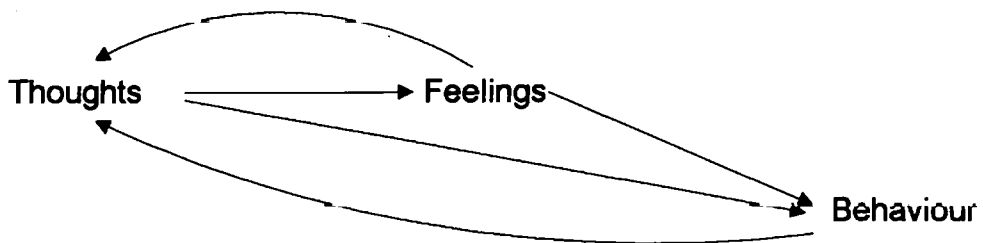


FIGURE 16 An alternative conceptualisation of the relationship between thoughts, feelings and behaviour



6.2.2.2 The conceptual model

Figure 14 (p.196) is a conceptual model illustrating the relationship between beliefs, feelings and behaviour when a parent and a young person who wets the bed interact in (or in relation to) a situation related to bed wetting. It illustrates "mutual simultaneous shaping", one of the central axioms of the naturalist paradigm (Table 1), being acted out in practice. While acknowledging the uniqueness of the beliefs that each individual brings to any situation, the organisation of beliefs into schemata helps to account for the repetitive patterning of the behaviour actually described by family members.

It is proposed that parents come to any situation related to bed wetting with a coherent, organised set of inter-related beliefs about it called a schema (Section 6.2.2.1). The schema is the cognitive basis of the parent's attitudes towards bed wetting (Section 6.3.2). This collection of beliefs and feelings is based in part on the parent's past experiences with this child and perhaps as a former bed wetter (Section 6.5.1).

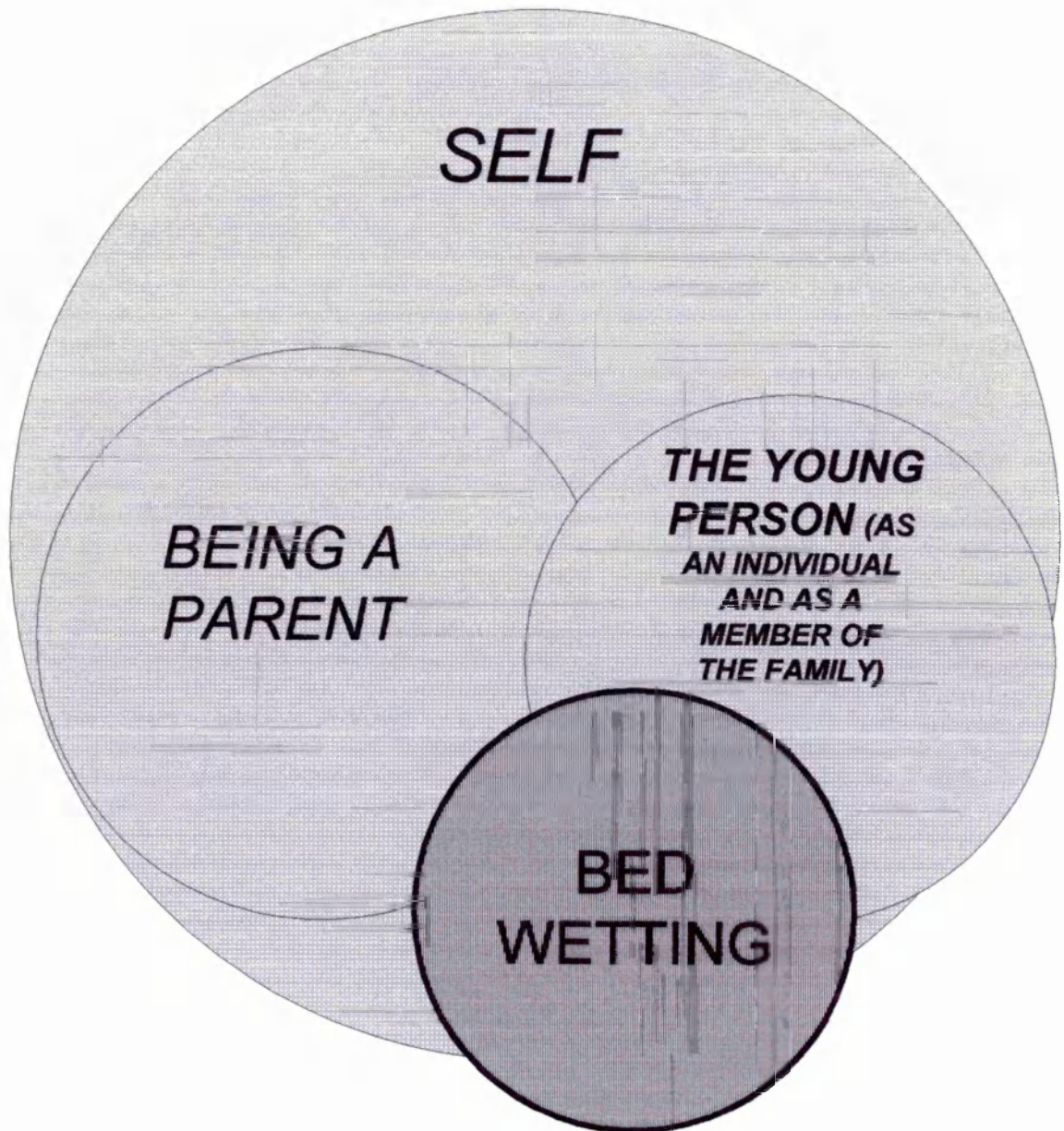
It is suggested that parents bring many other, more general beliefs to the situation, such as beliefs about:

- **self** (including beliefs about their capacity to control what happens to them in general)
- **being a parent** (internalised cultural norms and values about what a "good" parent "should" do)
- **the young person, as an individual and as a member of the family.**

These beliefs can be conceptualised as being organised into a "system" (Figure 17). The term "system" is used to suggest an integrated whole in which the parts are inter-connected with one another, perhaps in complex ways. The system as a whole is unique to the individual. Each subsystem is a set of topic related beliefs.

It is suggested that beliefs from within and between many sub-systems, interact in dynamic, conditional and often predictable ways. Taken together, the beliefs that the parent brings to the situation help to determine the parent's unconscious attitudes and response to the young person's bed wetting and to determine the actions consciously taken.

FIGURE 17 Some components of the parent's belief system



The schemata constructed by parents about bed wetting are both explanatory and predictive. They help the parent to make sense of what is going on and can help to contribute to the parent's sense of control over the situation. In these ways the parents' schemata are not unlike the theories created by researchers to help them to explain and perhaps predict certain phenomena (Section 6.1). Both theories and schemata are organisations of knowledge in which relationships between concepts or components are postulated.

When a parent encounters a situation related to bed wetting, it is suggested that the parent evaluates and interprets the situation, with the help of the schema, which acts in much the same way as a theoretical lens. It enables the parent to decide almost instantaneously whether the situation is:

- good or bad
- appropriate or inappropriate for the young person's age
- within/outwith the young person's control
- within/outwith their own control
- confirmatory or disconfirmatory of their beliefs about bed wetting and the young person more generally (Figure 14, p.196).

The parent's bed wetting schema influences those aspects of the situation that the parent attends to, the inferences drawn, and the information that passes into the parent's memory.

The parent's cognitive appraisal and interpretation of the situation leads to positive or negative feelings, which may be visibly expressed through body language and may be verbally articulated. The parent's interpretation of the situation also leads to action or inaction. The nature of the parent's action, when taken, may, however, have been modulated by a number of intervening cognitions: such as the perceived priority of bed wetting on the parent's agenda for action ("Do I want to do anything about it just now?"); the anticipation of positive or negative consequences of action or inaction at that moment ("What will happen if I ...?"), and an awareness of the beliefs of other family members and society more generally about what bed wetting is and what a "good" parent "should" do in the circumstances ("What will others think of me if I?").

It is suggested that like their parents young people who wet the bed and who find themselves in any situation related to bed wetting, come to the situation with a ready made "system" of beliefs which include beliefs specific to bed wetting and more global beliefs about:

- self
- self, as seen by others (this includes their parent's evaluation of them as a person)
- being a child in this particular family (Figure 18).

The young person evaluates the parent's response to the situation in relation to his personal schemata about himself as a person and himself as a bed wetter. He interprets his parent's behaviour as a positive or negative evaluation of himself and as confirmatory or disconfirmatory of his beliefs about himself and his control over the bed wetting.

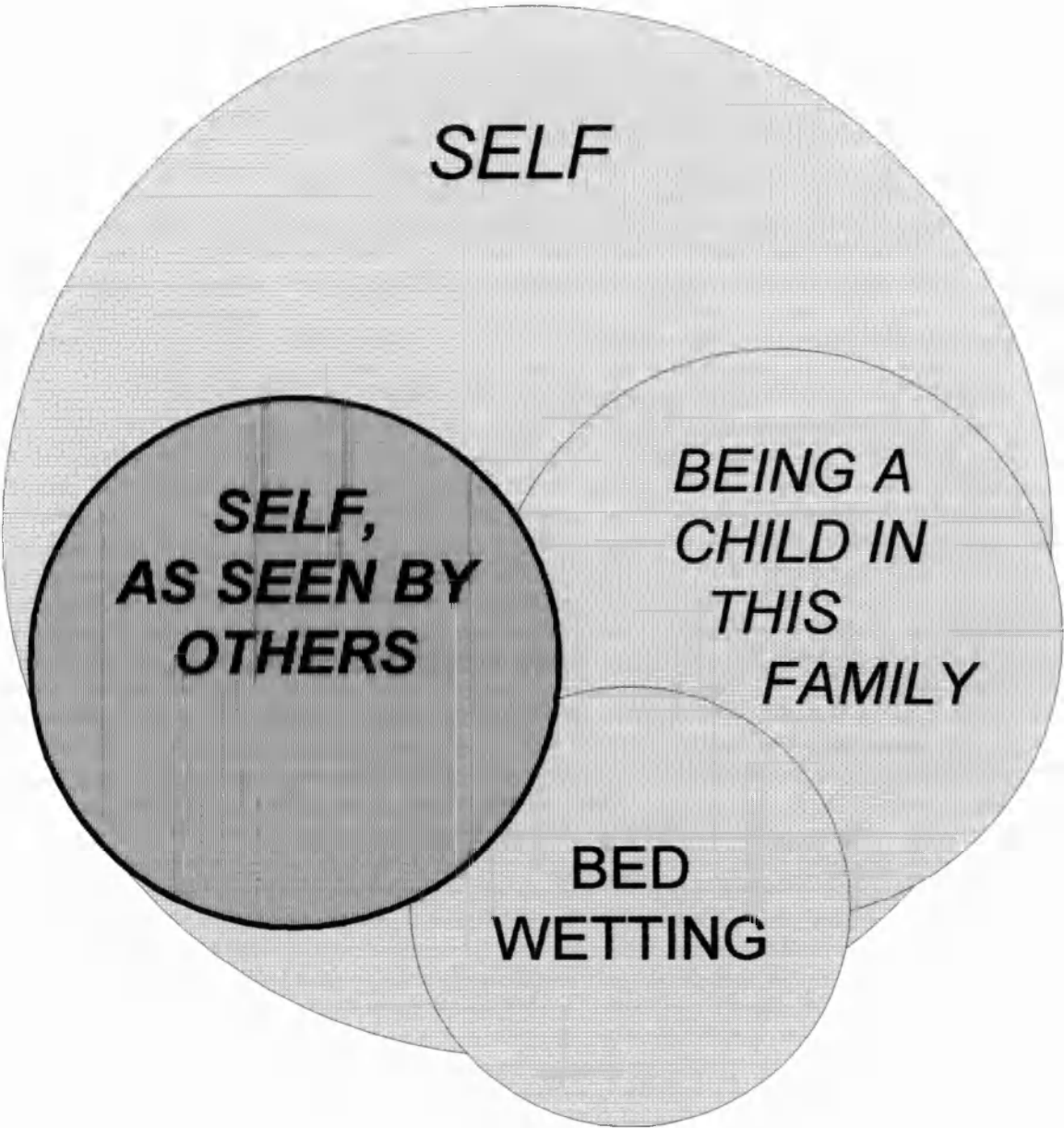
It is suggested that beliefs can be changed at any time as a result of a re-evaluation of the situation, but that in reality beliefs about bed wetting are often tenaciously held, in spite of contradictory evidence, which may be "explained" with the help of an elaboration of the individual's personal schema.

It is further suggested that when parents and young people interact and respond to each other's behaviour time after time, perhaps over many years, each individual may for the most part merely be seeing what he or she expects to see. This reaffirms the individual's personal beliefs about bed wetting and the other family members' control over it. This may or may not be helpful for a resolution of the situation in the longer term. It depends very much upon what the contents of the family members' schemata are.

6.2.2.3 The model's limitations

In this study beliefs have come to be recognised as important determinants of behaviour but it is accepted that the relationship between beliefs, feelings and behaviour is likely to be much more complex than Figure 14 suggests. In this study a number of intervening conditions have been identified which seem to be influencing people's choices and actions. It is acknowledged that many factors determine purposeful and unconsciously motivated behaviour and that it is highly probable that in any given situation these factors are interacting in complex ways.

FIGURE 18 Some components of the young person's belief system



The focus of this study has been on the beliefs brought to situations relating to bed wetting by different family members. These beliefs can be regarded as the "contents" of the psychic system (Leyens and Codol, 1994 p.91). No attempt has been made to explore the cognitive processes whereby information coming from the experience of relating to others, from memory and directly from the senses is received, selected, transformed and built into personal "knowledge", and organised into a schema. This is outwith the scope of this study.

A discussion of the influence of the individual's personality on their evaluation and interpretation of events is barely touched upon, yet it could be an important contributory factor. A discussion of the limits of family members' influence and the interplay between nature and nurture as determinants of parents' and young people's responses to bed wetting is also beyond the scope of this thesis. A general discussion of these issues can be found, for instance, in Plomin and Daniels (1987), Plomin (1994) and Rowe (1994).

This study merely illuminates some aspects of a complex reality.

6.2.2.4 The application of the model

Analysis of data from this study has led to a greater understanding of the nature of lay beliefs about bed wetting held by family members where one member is a bed wetter, and of the consequences which may arise when certain beliefs are held.

A classification of parents' attitudes towards bed wetting and their bed wetting child is given in Section 6.3. It is argued that these attitudes are based on a number of inter-related beliefs about bed wetting and the young person's and the parents' control over it. Young people's attitudes towards bed wetting and the beliefs that underpin them are described in Section 6.4. The social origins of parents' and young people's beliefs and attitudes are described in Section 6.5. It is suggested in Section 6.5.3 that family members' attitudes towards bed wetting are reinforced as they interact with one another from day to day.

6.3 Parents' beliefs about and attitudes towards bed wetting

6.3.0 Introduction

The parents' beliefs about the causes of bed wetting are reviewed in Section 6.3.1. Parents' attitudes towards their children's bed wetting are discussed in Section 6.3.2. Parents' attitudes are shown to have powerful emotional and social consequences for themselves and their children and to help to determine the supportiveness or otherwise of the emotional climate within the home in which the young person is trying (or not trying) to learn the skill of becoming reliably dry at night. The possible origins of parents' beliefs and attitudes are described in Section 6.5.1.

6.3.1 Parents' beliefs about the causes of bed wetting

The beliefs of the parents in this study about the possible causes of their child's bed wetting are summarised in Table 15. They can be broadly subdivided into three categories:

- physiological problems
- psychological attributes of the young person
- the young person's response to a negatively perceived event within or outwith the family.

These findings are broadly similar to the findings of Haque et al (1981) and Butler and Brewin (1986).

In a survey of 1,435 parents of children consecutively referred to the paediatric department of one of nine medical centres in the United States, Haque et al (1981) found that more than one third of the parents of both bed wetters and non bed wetting children believed that bed wetting had an emotional cause. Parents of bed wetters were more likely than the parents of non bed wetters to attribute the cause to deep sleep and were more likely to attribute it to a condition which ran in families. This may be a reflection of the parents' own personal experience of bed wetting in some cases.

In Butler and Brewin's (1986) study heavy or deep sleep was easily the most endorsed cause of bed wetting by parents, followed by two attributes of the young person as a "worrier" or "easily upset". With the exception of deep sleep, physiological problems tended to be regarded as less significant than psychological causes by the parents in the present study and in the two studies reported above.

TABLE 15 Parents' beliefs about the causes of bed wetting

| PHYSIOLOGICAL CAUSE | PSYCHOLOGICAL CAUSE | |
|--|---|---|
| | AN ATTRIBUTE OF THE YOUNG PERSON | THE YOUNG PERSON'S RESPONSE TO AN EVENT WITHIN OR OUTWITH THE FAMILY |
| <p>deep sleep</p> <p>a problem with the "plumbing" e.g. small bladder</p> <p>puberty, (hormonal)</p> <p>when ill</p> | <p>laziness</p> <p>attention seeking</p> <p>mood at bed time</p> <p>"in his mind"</p> <p>still to learn how</p> | <p>marital conflict</p> <p>parents separating</p> <p>mother going in to hospital</p> <p>death of the father</p> <p>poor relationship with father</p> <p>child abuse</p> <p>sibling rivalry</p> <p>arrival of a new baby</p> <p>watching a frightening film</p> <p>worried about "something" (cause unknown)</p> |

This runs counter to many health care professionals' belief that bed wetting is primarily a pathophysiological problem (Section 2.2.1). The studies of Haque et al (1981) and Butler and Brewin (1986) do not indicate which parents hold which attributional beliefs and with what consequences. It was found in the present study that the parents' attributional beliefs were on some occasions the basis of methods that some parents tried for themselves to encourage the bed wetting to stop (Section 5.5). These beliefs did not, however, by themselves, seem to account for parents' different attitudes to their child's bed wetting, which are described below.

6.3.2 Parents' attitudes towards bed wetting

There are many definitions of attitude in the literature. Bernstein et al (1991, p.A-14) define "attitude" as:

"A predisposition toward a particular cognitive, emotional, or behavioural reaction to an object, individual, group, situation, or action."

Baron and Byrne (1994, p.129) suggest that attitudes involve associations between attitude "objects" (that is any aspects of the social world) and evaluations of those objects, and define attitudes as:

"... evaluations of various objects that are stored in memory."

An attitude can be thought of as a personal perspective or viewpoint about something and it has three components: a cognitive component, based on beliefs which are organised into schemata (Section 6.2.2.1); an emotional component, arising from an evaluation of something as desirable or undesirable, and a behavioural component, that is a relatively stable and enduring way of acting toward the object of the attitude (Bernstein et al, 1991; Stahlberg and Frey, 1994). The relationship between beliefs, feelings and behaviour is discussed in Section 6.2.2.1 and illustrated in Figure 14 (p.196).

A classification of parents' attitudes towards bed wetting

From talking with parents in this study four factors have been found to be particularly important as determinants of behaviour. Certain combinations of these beliefs have been found to be strongly predictive of: a parent's overall attitude to the young person's bed wetting; their behaviour towards

the young person, and the emotional and social consequences of that behaviour for the young person and themselves. The factors found to be important are:

- the parents' definition of the bed wetting as appropriate or inappropriate for the young person's age
- the extent to which the bed wetting is regarded as a cause for concern
- the parents' beliefs about the young person's capacity to control the bed wetting
- the parents' beliefs in their own capacity to influence the situation at the present time and in the future.

It is suggested that the parent's attitude to his or her child's bed wetting can be classified into one of three broad categories:

- (a) acceptance and tolerance
- (b) ambivalence
- (c) rejection and intolerance.

Two of these categories have been further subdivided according to the parents' optimism about the young person becoming reliably dry at night in the future.

Using Strauss and Corbin's (1990) axial coding paradigm (Section 3.9.4) as a framework the causal conditions, intervening conditions, interactional strategies and consequences of these attitudes are summarised, in general terms, in Table 16. The causal conditions form part of the parent's schema about bed wetting (Section 6.2.2.1).

Before describing each of these attitudes and their consequences in more detail, it is important to make some general points.

The seven attitudes described are not regarded as personality traits, in the way for instance that Butler et al (1986, 1990, 1993) used the term "maternal intolerance" to imply a stable trait of the mother (Section 2.4). Rather, these seven attitudes are regarded as differing perspectives which parents bring to any situation relating to bed wetting at a point in time, based on certain beliefs held at that time, which give rise to certain general consequences, influenced in practice by many intervening conditions.

TABLE 16 Parents' attitudes and responses to their child's bed wetting: causal conditions, intervening conditions, interactional strategies and consequences
 (The structure of this table is based on Strauss and Corbin's (1990) axial coding paradigm (Section 3.9.4))

| | PARENT'S ATTITUDE | | | | | | | |
|---|--------------------------|---------------------|--------------------|-------------------------|-------------|-----------------------|---------------------------|-------------------|
| | ACCEPTANCE AND TOLERANCE | | | | AMBIVALENCE | | REJECTION AND INTOLERANCE | |
| | PRIMARY UNCONDITIONAL | TRANS- ITIONAL | RESIGNED PRAGMATIC | OPTIMISTIC PRAGMATIC | | | PRO- ACTIVE | RESIGNED REACTIVE |
| A. CAUSAL CONDITIONS | | | | | | | | |
| 1. Bed wetting is defined by the parent as appropriate for the young person's age | YES | YES | NO | NO | | NO | NO | NO |
| 2. The parent is concerned that the young person still wets the bed | NO | YES, TO SOME EXTENT | YES | YES, TO VARYING EXTENTS | | YES | YES | YES |
| 3. Parent believes that the bed wetting is within the young person's control | NO | NOT COMPLETELY | NO | NO | | PERHAPS | YES | YES |
| 4. Parent believes that he/she has: | NO | YES | NO | YES, IN SOME WAYS | | PERHAPS, IN SOME WAYS | YES | NO |
| a. the capacity to influence the situation now | | | | | | | | |
| b. the capacity to influence the situation in the future | YES | YES | NO | YES | | PROBABLY YES | YES | NO |

| PARENT'S ATTITUDE | | | | | | | | |
|--|--|--|--------------------|--|---------------------------|---|---|--------------------------|
| | ACCEPTANCE AND TOLERANCE | | | AMBIVALENCE | REJECTION AND INTOLERANCE | | | |
| | PRIMARY UNCONDITIONAL | TRANSITIONAL | DESIGNED PRAGMATIC | | OPTIMISTIC PRAGMATIC | PROACTIVE | DESIGNED REACTIVE | |
| B. <u>PHENOMENON</u> | | | | | | | | |
| Parent's overall attitude to the young person's bed wetting | Parent accepts and tolerates a situation which he/she believes; | cannot be changed now, but will change in time | should change soon | cannot, or is unlikely to, change ever | could change soon | Parent has mixed feelings about a situation which he/she believes can probably only be changed by the young person, facilitated perhaps by the parent's encouragement | Parent does not accept and is not prepared to tolerate a situation that he/she believes can be changed; | only by the young person |
| C. <u>INTERVENING CONDITIONS</u> | 1. Parent's beliefs and feelings about: <ul style="list-style-type: none"> a) parenting e.g. the appropriateness/inappropriateness of the use of physical punishment to discourage unacceptable behaviour b) the young person as an individual and as a member of the family c) the quality of their relationship with the young person more generally 2. The priority of bed wetting on the parent's agenda for action 3. The attitude of the parent's spouse or partner, wider family and friends to the young person's bed wetting | | | | | | | |
| D. <u>INTERACTIONAL STRATEGIES*</u> | *(The form that these strategies take depends upon the intervening conditions and the way that these interact) | | | | | | | |
| 1. Parent takes responsibility for helping the young person to learn the skill of being dry at night | YES | YES | NO | YES | YES | NO | | |

| PARENT'S ATTITUDE | | | | | | | |
|--|--------------------------|-------------------|-----------------------|-------------------------|-------------------|---------------------------|-----------------------|
| | ACCEPTANCE AND TOLERANCE | | | | AMBIVALENCE | REJECTION AND INTOLERANCE | |
| | PRIMARY UNCONDITIONAL | TRANS- ITIONAL | RESIGNED PRAGMATIC | OPTIMISTIC PRAGMATIC | | PROACTIVE | RESIGNED REACTIVE |
| D. <u>INTERACTIONAL STRATEGIES*</u> (continued) | | | | | | | |
| 2. Parent blames young person on those occasions when he/she loses night time bladder control | NO | NO | NO | NO | YES SOMETIMES | YES | YES |
| E1. <u>CONSEQUENCES FOR YOUNG PERSON</u> The emotional and social environment for learning to be dry at night (if this is possible) is supportive | YES | YES | YES | YES | MIXED | NO | NO |
| E2. <u>CONSEQUENCES FOR PARENT</u> In relation to bed wetting , feelings of: a) anger towards the young person | NO | NO | NO | NO | YES, SOMETIMES | YES, OFTEN | YES, VERY OFTEN |
| b) frustration at the situation | PERHAPS | PERHAPS | YES | PERHAPS | YES | YES | YES |

These attitudes are not regarded as stable or necessarily consistently held over time. Some of the ways in which these perspectives are thought to change over time are illustrated in Figure 19 which is empirically based. It is suggested, that even within a short period of time, perhaps even within a single interaction with a young person, a parent can vacillate between two of these "positions", for instance between ambivalence and rejection. Some patterns did, however, appear to be more ingrained, for example resigned pragmatic acceptance and tolerance, and resigned rejection and intolerance. While optimistic pragmatism appeared to be the predominant attitude of over half the mothers in this study it is important to emphasise that at least half of these mothers had come to this position from an attitude of rejection and intolerance (Figure 19) which had been a relatively stable attitude for them until they had come to believe that the young person could not control the situation.

Following definitions of the broad categories of: acceptance and tolerance; ambivalence, and rejection and intolerance, each of the attitudes, summarised in Table 16 is described below, with illustrations from parents' own accounts of their beliefs, feelings and behaviour.

Acceptance and tolerance

Acceptance and tolerance are inter-related constructs with several shades of meaning. "To accept" is defined in The Chambers Dictionary (1994, p.9) as:

"... to take (something offered); to receive (with approbation, favour, consent, resignation or passivity) ...to view favourably or to tolerate ..."

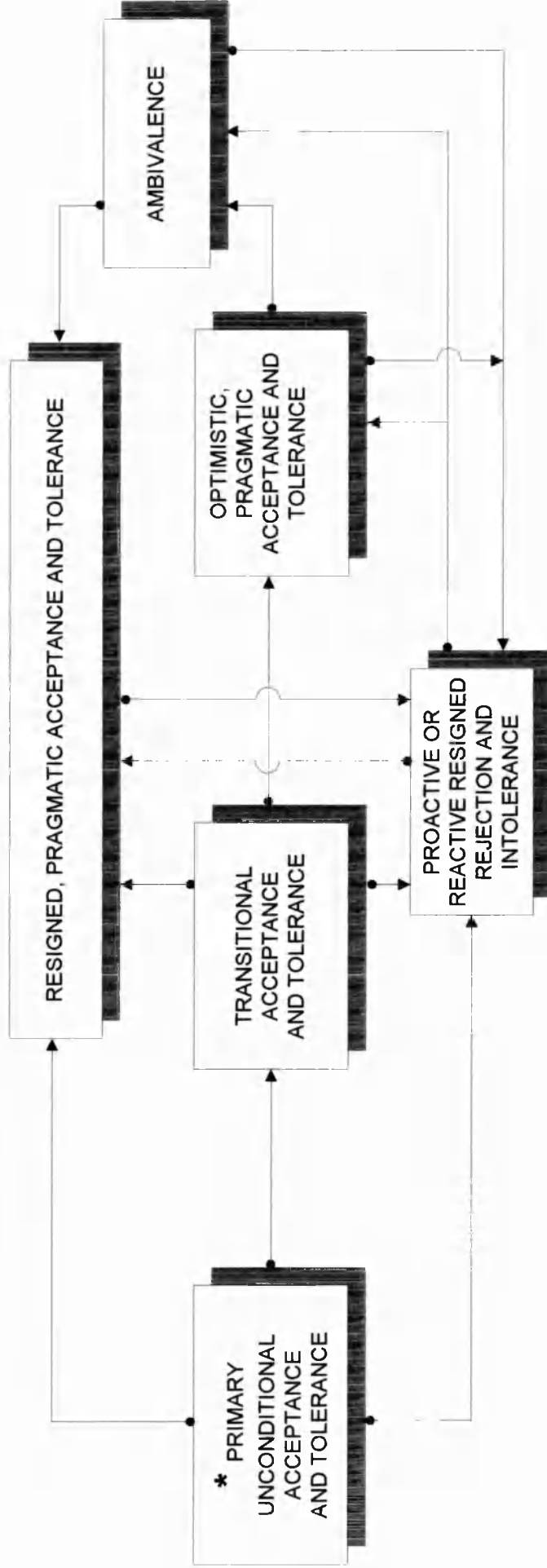
While it is unlikely that parents welcome their child's lack of night time bladder control with "approbation" or "favour" some parents seem to consent to it unconditionally, others to tolerate it and others to be resigned to it.

Tolerance is defined as:

"... the ability to resist or endure pain or hardship; the disposition, ability or willingness to be fair towards and accepting of different ... beliefs and opinions; ..."

The Chambers Dictionary (1994) p.1821

FIGURE 19 Parents' changing attitudes to a young person's bed wetting
(see Table 16 and Section 6.3.2)



Notes:

- * The parent may take any one of many routes originating from an attitude of primary unconditional acceptance and tolerance of lack of bladder control in a neonate.
- The parent re-evaluates the situation (perhaps aspects of the situation have changed) and adopts a different attitude to the young person's bed wetting. The change may be sudden or gradual. The changes can occur at any time along the young person's developmental path. The sequencing indicated corresponds to the sequencing suggested by the data from this study, but other sequences are possible.

Tolerance suggests a tendency to endure something which may not be pleasant and to treat others fairly, that is justly, reasonably and with forbearance. The definition of "tolerant" adds another shade of meaning:

"...capable of enduring (e.g. unfavourable conditions...) without showing serious effects ..."

It is suggested that parents who are able to be tolerant of their child's bed wetting experience fewer negative emotions in relation to it (Table 16). Certainly those moments of frustration which are experienced by tolerant parents seem to be less pervasive and persistent than is the case for parents whose overall attitude is ambivalent or intolerant. For accepting parents the frustrations were largely related to the practical difficulties associated with the management of the consequences of bed wetting such as the wet sheets and perhaps the wet child (Section 5.1.2) rather than a negative evaluation of the young person as a bed wetter.

Acceptance is a word which describes both an attitude (which has emotional and behavioural components) and a feeling. Ford (1992, p.149) describes the way in which "acceptance", which he groups with affection and love, can help to maintain social relationships:

"The emotion of *acceptance - affection - love* facilitates co-operative social functioning, the development of satisfying interpersonal relationships, and the sheltering and nourishing of helpless persons by supporting the process of interpersonal bonding and the development of mutual commitment and trust between people."

He suggests that this emotion is associated with caring, sharing and service to others and sends the message to the object of the emotion: "We're all in this together".

As is illustrated in Table 16, all the parents whose overall attitude towards the young person's bed wetting is one of acceptance and tolerance believe that the young person cannot yet control his or her bladder functioning at night. In this sense the parent regards the child as helpless and is prepared to help him or her to learn to be dry at night, unless it is known that the acquisition of night time continence can never be achieved for pathological reasons. The principal differences that parents within this broad category bring to any situation related to bed wetting are their different beliefs about their own capacity to influence the situation in a positive way (now, or in the future) and their

beliefs about the appropriateness of the bed wetting for the young person's age. The four sub-categories of the attitude of acceptance and tolerance are described below.

Primary unconditional acceptance and tolerance

Primary unconditional acceptance and tolerance is defined as acceptance and tolerance of a situation that the parent believes cannot be changed now but will change in time (Table 16). This attitude is described as primary and unconditional in that all (or almost all) parents begin with this attitude when the child is born and maintain this stance for the first few months of the child's life and perhaps for much longer (Figure 19).

During this period parents define lack of bladder control as appropriate for the child's age and they are therefore not concerned about it because the collective wisdom within their local community and the wider society in which they live (Figure 9) is that being dry at night is a skill which children are not born with and which they learn in time.

The child is not blamed for the lack of control although the parents may feel frustrated from time to time with having to deal with the practical consequences of wet nappies, and perhaps a wet bed.

Transitional acceptance and tolerance

Transitional acceptance and tolerance is defined as acceptance and tolerance of a situation which parents expect will change soon. This attitude is described as transitional in that the parents regard the child's lack of night time control as a stage which the child will shortly move beyond. The parents' behaviour is facilitative. The infant is still regarded as a "learner" and parents are usually prepared to tolerate "accidents" during the stage of the learning process when attempts are made to establish control without containment, that is when the child is taken out of nappies on an experimental basis. The parents may feel frustrated if their child appears to be a slow learner, compared to other children of a similar age in the neighbourhood. This raises the question: "At what age do parents begin to become concerned about a child's lack of night time continence?"

In the present study, contrary to many health care professionals' definitions of bed wetting (Section 2.2.1) most parents said that they had become concerned about the bed wetting some time before the child was of school age.

The survey conducted by Haque et al (1981) found that the mean expected age for attaining night time bladder control was 3.18 years for the 346 parents of bed wetters, compared with 2.61 years for the 1033 parents of non-bed wetting children. It is not known from Haque's study whether the parents who set a higher age for the attainment of dryness had been bed wetters themselves (whether or not their child was a bed wetter) and had learned from experience that achieving night time dryness before the age of four years is not always possible.

In the present study six mothers said that they themselves had wet the bed (Appendix XIII), until the ages of 5, 6, 10, 11, 15 and 18. With only one exception these mothers were still concerned that their child was not dry before going to school but several stated that their concern was because of the attitude of other people should the discovery be made (Section 5.4.3) rather than their own expectation that the child should be dry.

Resigned pragmatic acceptance and tolerance

Resigned pragmatic acceptance and tolerance is defined as acceptance and tolerance of a situation which the parent believes cannot, or is highly unlikely to change. This attitude is described as pragmatic and resigned because the parents have realistically given up hope that the situation can be changed, in the light of medical evidence that the young person has an incurable pathological problem or the evidence from their own experience that nothing that they have done has made a difference and the expectancy is that there is nothing more that can be done.

The parent does not actively try to teach the young person to be dry at night but neither is the young person consistently blamed for loss of night time bladder control. The parent may frequently feel frustrated and at times despairing about a situation which is regarded as "never ending". The parents may be angry on occasion with the young person but this is said to be because the young person is

not taking sufficient responsibility for those tasks which are within his or her control, such as managing the practical consequences of the incontinent episodes. In the present study there were three clear examples where this attitude was or had been consistently in evidence.

Michael (age 8) was the only young person in this study for whom the cause of the bed wetting was known with any certainty (Section 4.3.0). Michael's mother had to get up to him twice a night on average to change his wet nappy and she had had this to contend with since Michael was born (Section 5.1.1). He also had problems with day wetting. Both Michael's parents were stoical about it but his mother did feel worn down by the constant need to change Michael night and day. She was most frustrated when Michael seemed unaware that he had wet himself:

MRS M: But - he will go about wet, I keep saying, you know - 'you're not getting a row for being wet, but you're getting a row for going about like that', you know - and I find that difficult to cope with."

Mother of Michael (age 8) 1211/9 p.19

For both parents, however, the predominant concern was that Michael would be hurt by the comments of other people. The frustration that both parents felt at times was openly acknowledged within the family and Michael could actually make a joke about it:

"MOYA: So what's the worst thing about it, about being wet, do you think?

MICHAEL: Um ... (pause)

MRS M: Mummy being at you all the time!

MICHAEL: Yes (laughs). Thank you for saying that, Mum, you've had a brain wave!"

Michael (age 8) and his mother 3214/68 p.3

Michael was such a cheerful child. He seemed to have everybody's sympathy from the taxi driver who took him to school to relatives and friends who took him to watch football (Section 5.4.4) because he patently could not help wetting himself and indeed he was seen to be suffering as a result of his chronic health problem. Michael's father summed up the parents' feelings about Michael's bed wetting:

"MR M: I sometimes think - we maybe try to protect him too much. Up until, especially up 'til he went to school, I think we sort of done everything for him and helped him every way we could, and then when he went to school we started telling him to do things ... 'Come on, you're getting big now, you should be able to realise that this is happening'. And he comes back with an answer like, 'Do you not know I've got a kidney problem?' (Everybody laughs) And you sort of say to yourself, 'God, I know you've got a kidney problem!' He just comes back with these one or two liners - he's quite a character... Sometimes you could murder him and other times, you know, he breaks your heart."

Father of Michael (age 8) 6172/35 and 68 p.9 and 17

Although it was a "never ending thing" which continually made both physical and mental demands on them, Michael's parents had come to an acceptance of the situation which they believed they could not change and which was helped when the burden that they were bearing was seen to be recognised by others, for instance when Michael's mother was given an attendance allowance:

"MRS M: ... you feel as if somebody's patting you on the back and saying, 'you know, that's fair enough'. "

Mother of Michael (age 8) 6172 /56 p.14

Two other mothers, the mothers of Alison (age 9) and Carol (age 17) had also come to an attitude of resigned pragmatic acceptance and tolerance of a situation which both felt unable to influence. This attitude can be summarised as "giving up":

"MRS A: ... you feel helpless, that's exactly it. You don't know what to do for the best for her. She's wetting the bed, you try everything you get suggested to you, nothing's worked and still the bed wetting goes on. You think, the older she gets, it's never going to end ... It's just total despair. We gave up, you know. Leave it, ignore it, we've done everything else, it can't get any worse. We thought we were going to be doomed for the rest of our days to have her as a bed wetter."

Mother of Alison (age 9) 1211/30 p.12

After seven years of unsuccessful attempts to help her daughter to be dry at night Alison's mother had made the conscious decision to stop actively attempting treatments which were patently not working for her. She described the way in which everyone's spirits in the household had improved once the decision was made to do nothing. Before this level of acceptance and tolerance was reached Alison's mother had punished her daughter for the bed wetting when she believed that her daughter had more control over the situation than she was choosing to exercise (Section 5.5.3). Adopting an attitude of resigned acceptance and tolerance does not mean that the parents do not wish that the situation was different. It is merely an acknowledgement by them that nothing more can realistically be done, accompanied by a decision to make the best of the situation that they find themselves in. As such its purpose is one of damage limitation.

The mother of Carol (age 17) had also come to the stance of resigned pragmatic acceptance and tolerance of a situation which she believed was unlikely to change or at least to be within her control. Carol's mother had wet the bed herself until the age of 16 and Carol's father had wet the bed until he

was 24 years old so perhaps the expectancy was that Carol would wet the bed into adulthood. Carol's mother and her new partner were not angry about the bed wetting itself, but at Carol's lack of motivation to help herself on those mornings when she did wake up wet (Section 6.5.3).

Optimistic pragmatic acceptance and tolerance

This attitude is defined as acceptance and tolerance of a situation which the parent believes could soon change for the better. This attitude is described as optimistic and pragmatic because the parent is hopeful and perhaps confident that the young person will attain night time bladder control in the future but takes a realistic view in the meantime, recognising that the attainment of night time bladder control is not easy for some young people.

These parents believe that they are able to influence the situation in a positive way to some extent but that they may not currently have the means to do so. They take responsibility for helping the young person to learn the skill of being dry at night. They do not blame the young person on those occasions when night time bladder control is lost, but they may feel frustrated by the consequences of the bed wetting such as the extra laundry (Section 5.4.1). The message which they convey to the young person is: "Bed wetting is something which happens to some people, you can't help it and you will grow out of it". These parents are often particularly empathetic towards the young person and express the concern that the bed wetting is stopping them from doing so many things (Section 5.4).

In this study five of the parents who had adopted the attitude of optimistic pragmatism were known to have had experience of bed wetting as a bed wetter themselves or from having lived at close hand with a bed wetting sibling (Section 5.2.3). These parents were quite unequivocal that the young person could not help wetting the bed:

"MRS I: I used to try that hard, you know. So I understand how he feels when he's dry for maybe a week and then he's right down in the mouth. I understand how I felt, so I can understand how he feels. It was really disappointing because he thought, 'this is it, I'm dry' - and then the next time you're back again, wetting again. I understand how he feels. Every time he thinks, 'this time,' and I say to him, 'keep your fingers crossed, maybe this is it', you know."

Mother of Ian (age 13) 1211/28 p.12-13

In these families the impression was clearly gained that the attitude of optimistic pragmatism had been consistently held over many years. The young person had never been punished for bed wetting, indeed the parents in each of these families said that they felt that the use of punishment would have been quite inappropriate (Section 5.5.3).

In at least four other families, however, parents whose current attitude seemed to be one of optimistic pragmatism, indicated that there had been a time when they had been far less tolerant of the situation. This had been when they had felt that the young person had more control over the bed wetting which they were choosing not to exercise.

Ambivalence

Ambivalence is defined as:

"Co-existence in one person of opposing emotional attitudes towards the same object."

The Chambers Dictionary (1994) p.48

Parents with an ambivalent attitude towards their child's bed wetting have mixed feelings about a situation which they believe can probably only be changed by the young person in the end. They believe that the young person may have more control over the situation than he or she is choosing to exercise yet at the same time they are perplexed that the young person does not exercise the control that they may have to combat the negative social consequences of bed wetting (Section 5.4).

These parents see their role as encouraging the young person to take responsibility for the situation for themselves and may go to some lengths to find the means to help the young person to achieve dry nights. They may blame the young person on those occasions when night time bladder control is lost and they become frustrated and at times angered by the young person's apparent lack of effort to help him or herself. They are also frustrated in those cases when the young person does not appear to be willing to play a part in the management of those consequences of bed wetting over which they could have some control.

However, these parents tend to have a good relationship with the young person on the whole and to have encouraged the young person to pursue interests which give them the opportunity to experience

success. These young people therefore tend to be sent a mixed message: "Overall you're OK, but the bed wetting is something which you should be able to control by now, and it is something which you could control if you made more of an effort to help yourself. When you want to, you will be dry."

Many parents may experience ambivalence about their child's bed wetting from time to time but in this study ambivalence was found to be a persistent attitude amongst the parents of some older bed wetters, where the parents felt that all the treatment options had been exhausted. In two cases the mothers expressed ambivalence in the face of their husbands' unequivocally stated belief that the young person could help themselves if they made more effort:

"MRS A: But what 16 year old would want to wet the bed every night?

SUSAN: No, but he doesn't really really want it, does he?

MRS A: Why? I could understand when he was tiny, and they used to say to us, OK, he likes the effect of a wet nappy round him. As a little toddler I can understand that, but a 16 year old boy - I mean, come on!! - at 16 years of age, nearly 17 - he's a young man. His thoughts are of young girls, and of dirty magazines and all that sort of thing that that age group go in for.

MR A: (coughs) I personally believe that will be the point at which the problem will go away."

Mother, sister and father of Anthony (age 16) 1411121/31 p.2

The attitude of Anthony's sister Susan is suggestive of sibling rivalry (Section 5.4.1). The mothers of Anthony (age 16) and Peter (age 15) were, however, wanting to give their sons the benefit of the doubt, even when all the evidence seemed to be that the young person was not making as much effort as they could be making to help themselves. It seemed to be a manifestation of maternal protectiveness (Section 5.2.1). In both cases the management of bed wetting was just one item of contention in a catalogue of others, relating to life with an adolescent.

For ambivalent parents, their inability, over many years, to exercise effective control over a situation where they believed that some control was possible had led to feelings of frustration and despair. In each case, however, the young person seemed without doubt to be the principal focus of the parents' concern:

"MRS P: It's just that you feel so frustrated that you can't help them ... You know the health visitor says, 'yes, it must be awfully hard having all these sheets to wash', but you get used to it. You know you don't see it as extra work, you feel more sorry for them because it's causing them a problem, embarrassment, whatnot."

Mother of Peter (age 15) 651/1 & 2 p.1

The negative consequences for the family as a social unit are described in Section 5.4.1. The consequences for the mothers were said to be pervasive:

"MRS A: It's frustration ... your whole life - because you always go to bed - wherever you go, whatever you do, it's on your mind ... I'm perhaps menopausal - you're frustrated, you're annoyed, you're hyper, you get PMT, you're a mother, you've had an argument with your husband, and you know - the shopping - it's the thing that comes back all the time, for ever."

Mother of Anthony (age 16) 1211/106 p.1

It was a chance conversation with Anthony's mother which influenced the researcher to embark on this study (Section 1.2).

Rejection and intolerance

Rejection and intolerance are inter-related constructs and are the converse of acceptance and tolerance. To reject is defined in The Chambers Dictionary (1994, p.1452) as:

"... to throw away; to discard; to refuse to accept, admit or accede to; to refuse; to renounce"

As a noun a "reject" is defined as: "... an imperfect article ..."

Intolerance is defined as:

" ... not able or willing to endure; ... persecuting; easily irritated or angered by the faults of others ..."

p.878

Parents who are intolerant of their child's bed wetting all have one belief in common. They believe that the bed wetting is within the young person's control. These parents are not prepared to accept and are disinclined to endure a situation which they believe can be changed but ultimately only by the young person. These parents experience feelings of frustration and anger in relation to the bed wetting. The parents who perceive themselves to be least able to influence the situation seem to experience these negative emotions particularly pervasively.

Parents within this broad category differ in two important respects:

- (1) the extent to which they believe that they are in control of their lives in general (which differentiates between the proactive and the reactive parents), and
- (2) their feelings of benevolence towards the young person in general, that is the extent to which their rejection and intolerance is situation-specific.

All these parents have a tendency to blame the young person on those occasions when he or she loses night time bladder control and tend not to provide a particularly supportive emotional climate for the young person to learn the skill of becoming dry at night.

Where the intolerance is situation-specific the message sent to the young person seems to be:

"Overall you are OK but in relation to the bed wetting you could act differently and you are not helping yourself". Where the intolerance is more generalised the message appears to be: "Overall you are not OK and in relation to the bed wetting you could act differently and you are disobeying my wishes."

Proactive rejection and intolerance

Proactive rejection and intolerance is defined as rejection and intolerance of a situation which the parent believes is largely within the young person's control. This attitude is described as proactive because these parents still believe that they have a role to play in encouraging the young person to take responsibility for stopping the bed wetting and in helping the young person to find the means to do so. These parents take the initiative, they actively seek new treatments and try to encourage the young person to persist with them. They follow up new treatment ideas which they come upon by chance, for instance through the media. They are determined to resolve the problem of the bed wetting. They may or may not exhibit benevolence towards the young person more generally.

The fathers of Anthony (age 16) and Peter (age 15) fall into this category. Both appeared to be benevolent towards their sons in many ways. Benevolence is a disposition to do good, to act out of kindness and with generosity. These parents seemed to be well disposed towards their children in general but they clearly disapproved of the bed wetting. Their rejection and intolerance is therefore seen to be situation-specific.

Having run out of physical explanations these fathers had come to what seemed to them to be the logical conclusion that the problem was a psychological one and therefore within the young person's control:

"MR P: Well, I'm no doctor, but maybe I'm wrong - but I think you've basically got two sides. You've got the plumbing side with the urologist, then you've got the psychological side. Now if the plumbing side is all right, it's either the chemistry of the body somehow or the psychological side. Once you can rule out these two points it's a matter of, in my opinion you've got to re-educate Peter ...try to get the message home to him ... but he just seems to shut off to it."

Father of Peter (age 15) 141121/15 p.5

Anthony's father had come to a similar conclusion:

"MR A: Well, I believe that this is all now, having been through the measures that we've been through - I believe this is all totally within his control (said calmly, but firmly)...Anthony - I suppose really as the result of the enuresis problem, has adopted the posture of not being a member of the family, in the social sense, he does things that he wants to do, he won't participate with the rest of us, he deliberately makes life difficult, now I believe that this is a conscious effort on his part to extract an attitude from the rest of us, so that he can heap more guilt on himself for the problem."

Father of Anthony (age 16) 141121/22 p.1

In his search for meaning Anthony's father was suggesting that Anthony received some kind of benefit from "extracting an attitude" from the rest of the family. He also suggested that Anthony was using the bed wetting as an excuse for other areas in his life where he perceived himself as failing. A consultation with a urologist had only served to confirm this father's views:

"MR A: Eventually Mr B (the urologist) and I sat down with Anthony and we talked about it and I told Mr B that I felt that Anthony was quite capable of controlling the situation, that it has now reached the stage that it wasn't a physical problem, it was a psychological problem. And as soon as we arrived at the point at which Anthony wanted it to work, it would work. And I rather got the impression that Mr B had also arrived at the same point, because medically there was very little else that he could do."

Father of Anthony (age 16) 141121/31 p.2

Anthony's father's theory about the cause of his son's bed wetting was based on other evidence, as well:

"MR A: ... if he was serious about this, he would take the tablets. If he was serious in times gone past, about being dry, he would have filled the chart in, but it was always a question of 'have you filled the chart in?' 'No'. So somebody else fills the chart in for him, whether it's good news or bad news. That doesn't say to me that he's actively involved in trying to want to resolve this problem."

Father of Anthony (age 16) 141121/86 p.2

The members of this family were locked in a self-perpetuating cycle of conflicting and strongly held beliefs, feelings and behaviour which had led to tension and distress for all concerned. The elements of this cycle are described in Section 6.5.

In contrast to the generally benevolent stance taken by Anthony's and Peter's fathers, the mother of Sarah (age 11) seemed to take a consistently punitive approach towards her daughter in situations both related and unrelated to bed wetting. Sarah's mother appeared to vacillate between pro-active rejection and intolerance and ambivalence towards her daughter's bed wetting. She said that she did at times feel very angry about it:

"MRS S: I mean I can sort of go off in a tirade and get really cross with her and tell her that I'm fed up with the smell ... and then you look at the child and you've got her feelings to consider, and then you feel sorry for what you've done, shouting and bawling. It's not her fault, you know, then you go on a guilt trip."

Mother of Sarah (age 11) 1521228/10 p.1

The dilemma for Sarah's mother was whether or not her daughter could control the situation. This mother had wet the bed herself until she was 10 years old:

"MRS S: I can remember being in more control of it than I let on. I was lazy ... more often than not I was with Billy (her brother) so it could be Billy who did it, it didn't have to be me. She (her mother) never knew who it was ... I was just lazy. That is how I wonder if she's like that, if she's doing that - it is warm and cosy in bed, you don't want to get up to go to the toilet."

Mother of Sarah (age 11) 14113/32 p.1

Sarah's mother had punished her daughter in many ways for wetting the bed (Section 5.5.3). She felt that health care professionals blamed her for her daughter's problems (Section 5.6.2). She had tried and persisted with many treatments for her daughter's bed wetting but to no avail (Section 5.6.1). She described her relationship with her daughter as poor and described her daughter as: "highly volatile", "manipulative", and "very secretive". The message sent to Sarah by her mother seems to be: "You could act differently and you are disobeying my wishes".

Before he had become reliably dry, through taking Triptizol, Martin's mother appeared to be sending her son the same message. When asked what his feelings had been when he did wet the bed, Martin replied:

"MARTIN: I cry ... 'You've to keep it dry'."

Martin (age 6) 3214/35 p.2

Martin's mother had insisted that he wear nappies (Section 5.1.3) and she had been intolerant of the bed wetting until she realised that her son could not help it.

Lazarus (1991) considers anger to be one of the most powerful emotions, which can have a profound impact on social relations as well as on the person experiencing the emotion. He suggests that what makes anger different from other negative emotional states (all of which he suggests derive from harm, loss or threats) is that blame is directed at someone or something.

To blame persons, rather than simply holding them accountable or responsible for harm, loss or threat suggests that the person believes that the object of their anger could have acted differently, that is they had control over the offending action. The inference is that the other person acted with volition, that is without proper regard for the sensibilities of the person offended.

Lazarus (1991) also suggests that any action that is deemed to be inconsiderate or malevolent contributes to the impression that the person has been demeaned, the angry person has suffered what is taken to be damage or threat to ego-identity, whether this is recognised consciously and admitted or not. He suggests that the word "offence" refers not merely to the frustration of a goal (though frustration certainly has emotional significance) but that it carries a special significance, namely a slight or injury to the person's own self.

Lazarus suggests that a powerful impulse arising from anger is to exact vengeance, that is to attack the person held responsible for the offence. He suggests, however, that people may act benignly and constructively on the basis of threat, enlightened self-interest, or strongly internalised ethical values. In other words, a person's anger may not be translated directly into actions although it is unlikely that the anger will remain totally invisible.

Anger seemed to be a particularly commonly experienced negative emotion amongst those parents whose attitude towards bed wetting is described as resigned reactive rejection and intolerance as is described below.

Resigned reactive rejection and intolerance

Reactive resigned rejection and intolerance is defined as rejection and intolerance of a situation which the parent believes is within the young person's control but outwith their (the parents') control.

This attitude is described as resigned and reactive because the parent has given up trying to influence the situation and merely reacts to events as they occur, usually in a negative way.

All the parents exhibiting this attitude appeared to have, or to have had, a poor relationship with the young person more generally. These parents had also consistently and consciously punished their children for bed wetting (Section 5.5.3). They were amongst the most angry as well as the most frustrated by it. In two cases the parents thought that the bed wetting was deliberate:

"MRS M: I mean she could get up but then there were nights she can be lazy. I mean you can walk into the room and she can be sitting up in the bed and says, 'I'm sorry, mum'. 'Right, OK'. And I just walk away."

Mother of Michelle (age 8) 1211/7 p.11

The relationship between Michelle and her mother did not appear to be good and her daughter was frequently punished for other misdemeanours. Gary's father was also convinced that his son deliberately wet the bed. His wife described the relationship between Gary and his father as poor and she explained her perception of the situation:

"MRS G: I feel if Alan (her husband) has been shouting at him and annoying him, I think Gary deliberately wets the bed, because when he does wet the bed and his dad's shouting at him and that, Gary looks at his dad and you can see the hate in his eyes."

Mother of Gary (age 5) 1411116/4 p.1

Gary's mother felt that this was a way in which Gary was able to retaliate when his father was angry with him because he knew that his father was unhappy about the bed wetting and particularly disliked the smell of the urine in the house.

Tracy's mother was also very angry about the bed wetting. She was finding it particularly difficult to manage four children on her own. Conversations within this household were chaotic experiences, in which arrangements to meet had been forgotten (Section 3.7.2) and the children could be found wandering through the house eating their meals at any time of the day. Perhaps for Tracy's mother the bed wetting was the last straw in a situation over which she already felt that she had very little control. Tracy's four year old sister had recently started wetting the bed as well and the girls shared a bedroom.

Life within the families of Michelle, Gary and Tracy seemed to be characterised by inter-personal conflict. This group includes the three natural fathers who were said by their wives to have abdicated from all responsibility for helping the young person to learn to be dry at night or to manage the consequences arising from the bed wetting in the meantime (Section 5.2.2).

These parents are sometimes scornful, contemptuous or disdainful of the young person's bed wetting. Ford (1992, p.150) describes the message attached to the emotion of "scorn - disdain - contempt" as:

"You know better than that - shape up or ship out!"

This is reminiscent of Stone's (1973) contention that bed wetting into adulthood can lead to rejection from the family and perhaps ultimately to homelessness, in some cases.

Certainly the nurturing quality displayed by accepting and tolerant parents in general, and by the ambivalent and proactive intolerant parents in situations other than bed wetting, seemed to be noticeably absent amongst those parents whose attitude was primarily one of resigned reactive rejection and intolerance. It is, however, not possible to say which came first - the poor relationship between the parent and the young person or the bed wetting (Section 5.4.1).

It may be, in some cases, that the young person's behaviour in response to their parents' intolerance, makes them less easy to live with than other children within the same family. The situation may be one of "mutual simultaneous shaping" - a situation which is coming to be recognised in the family literature (e.g. Brodrick, 1993; Gelles, 1995; and Muncie et al, 1995) and is discussed further in Section 6.5.3.

Many of the intolerant parents were having to cope with other problems at the time of the study and could well have been experiencing a phenomenon referred to by Burr and Klein (1994) as "stress pile up".

6.4 Young people's beliefs about and attitudes towards bed wetting

6.4.0 Introduction

The beliefs of the young people in this study about the causes of their bed wetting are reviewed in this section and compared with the results of a recent survey (Section 6.4.1). By themselves these beliefs do not seem to account for young people's differing attitudes towards their bed wetting and to treatment, and their feelings about themselves as bed wetters (Section 6.4.2). The possible origins of young people's beliefs and attitudes are discussed in Section 6.5.2.

6.4.1 Young people's beliefs about the causes of bed wetting

Unlike the complex coding tree developed to organise parents' beliefs about bed wetting, which was composed of 56 nodes, the tree developed to organise young people's beliefs about bed wetting was remarkably simple and of itself illuminating (Figure 20). The majority of the young people had no idea what was causing their bed wetting, or why they were wetting the bed less often than before, when they were beginning to achieve some dry nights. Most felt that they had little or no control over the situation and expressed varying degrees of optimism about the future. Sarah's response was typical:

"SARAH: I don't know why I do it, I just do it."

Sarah (age 11) 3311/2 p.1

In an attempt to be helpful some young people cast about for a possible explanation. In innocence John put forward a theory suggested to him by a friend:

"JOHN: Well my pal says, 'you must be having wet dreams'."

John (age 8) 3312/1 p.1

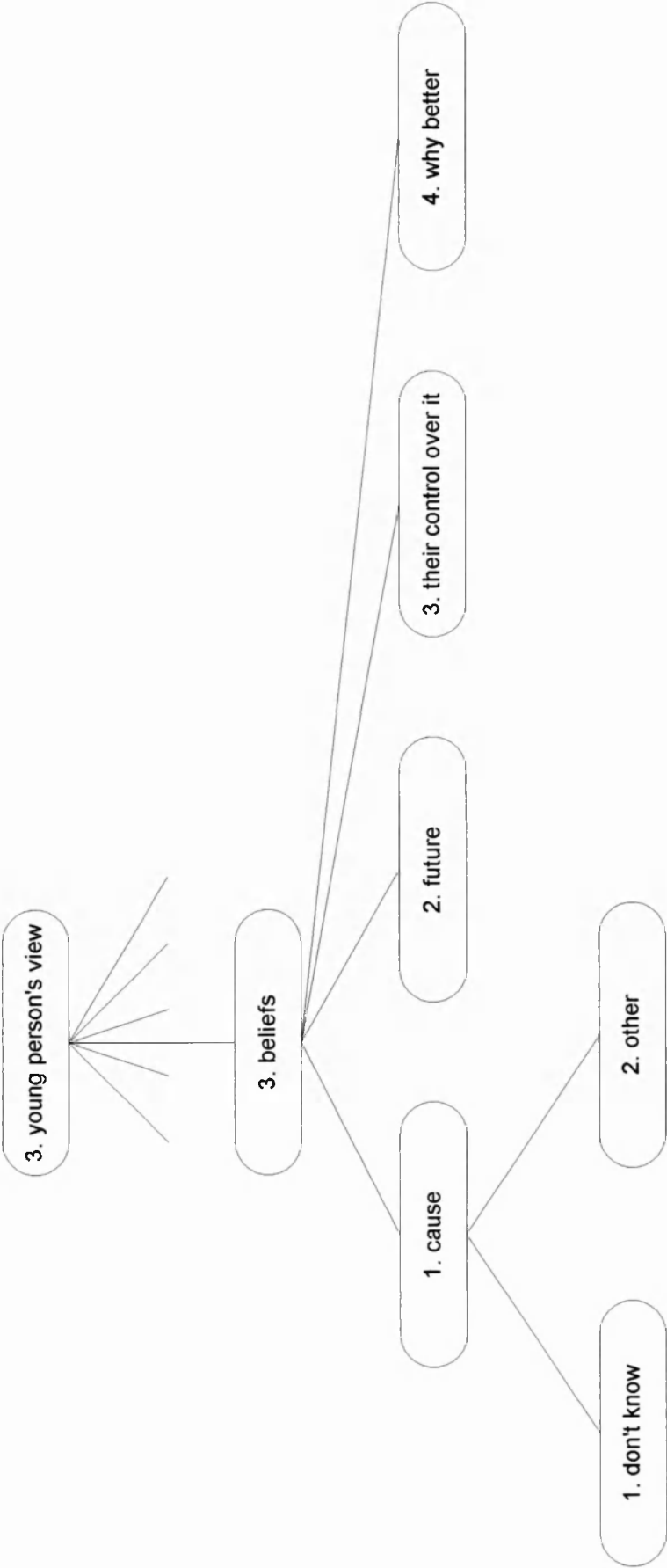
In contrast to Butler's (1994) study, described below, Anthony was the only young person to suggest that his bed wetting could be due to deep sleep. This was not a view held by his parents.

Carol thought that her bed wetting could be due to bad luck:

"CAROL: It was my bad luck for breaking four mirrors. ... 28 years bad luck!
(laughs)"

Carol (age 17) 3312/66 p.1

FIGURE 20 The hierarchical indexing (coding system) for young people's beliefs about bed wetting
(See Section 3.9.3 and Table 4 for an explanation of the indexing system and its features)



Carol offered a different explanation a little later on in the conversation, which she quickly regretted suggesting:

"CAROL: It could be the mind ...

MOYA: In what sort of way?

CAROL: In what sort of way? Why did I come out with that idea! I dinnae know. It could be, that's all I'll say, it might be.

MOYA: Has anyone said that to you or is that your idea?

CAROL: Mine."

Carol (age 17) 3312/88 p.1

It could be that other young people had their own personal theories about the cause of their bed wetting which they were reluctant to share. Perhaps they felt that their theory reflected badly on them as a person in some way. The inability of most of the younger children to articulate any explanation for their bed wetting may well be a reflection of the stage of their cognitive and linguistic development (Section 3.7.2.2).

In a study by Butler (1994) fifty children were asked to rate each of eight statements about the possible "biological" cause of their bed wetting, using a 0 - 6 Likert Scale. "I sleep too deeply" (p. 18) received the highest mean rating . When presented with a schedule listing ten "psychological" causes these children rated: "Fail to wake to full bladder signals" and "Not learned to hold through the night" (p. 34 - 35) as the most likely causes of their bed wetting. These are all causes over which the young people perceived themselves to have little or no control. The ages of the young people in Butler's (1994) study are not given. Asking young people to rate predetermined options may give the rather misleading impression that they are more certain of the cause of their bed wetting than is actually the case. Most of the young people in the present study seemed genuinely perplexed about why they wet the bed. They were vague with their explanations which, for the most part, seemed to lack conviction. It is argued below that young people's beliefs about their control over the bed wetting may be more potent determinants of both their attitudes and behaviour than the "biological" and "psychological" causes explored by Butler (1994).

6.4.2 Young people's attitudes towards bed wetting

As with parents, several factors have been found to transcend young people's specific attributional beliefs about bed wetting as determinants of their overall attitude to it, their feelings about it and their response to it. These factors include:

- the young person's concern about the bed wetting
- the young person's desire to be dry

and the young person's belief that he or she:

- has the capacity to influence the situation
- will one day be dry at night
- is or is not blamed for bed wetting by one or both parents.

It is suggested that the young people's attitudes towards bed wetting can be classified into one of four broad categories:

- acceptance and tolerance
- ambivalence
- rejection and intolerance
- resigned helplessness and hopelessness.

The first category has been further subdivided according to the young people's concern about the bed wetting and optimism about becoming dry in the future. Table 17 therefore describes and summarises seven attitudes of young people towards bed wetting, their antecedents and some of their consequences. As with parents' attitudes it is emphasised that these seven attitudes should not be regarded as consistent, stable traits. Rather, they are differing perspectives which young people bring to any situation they find themselves in relating to bed wetting. These perspectives may change over time, as illustrated in Figure 21, which is empirically based.

TABLE 17 Young people's attitudes towards bed wetting
(The structure of this table is based on Strauss and Corbin's (1990) axial coding paradigm (Section 3.9.4))

NA = not applicable

| | YOUNG PERSON'S ATTITUDE | | | | | |
|--|--------------------------|------------------------------|--------------------|-------------------------|-----------------------------------|--------------------------------------|
| | ACCEPTANCE AND TOLERANCE | | | AMBIVALENCE | PROACTIVE REJECTION & INTOLERANCE | RESIGNED HELPLESSNESS & HOPELESSNESS |
| | PRIMARY UNCONCERNED | HAPPY | RESIGNED PRAGMATIC | OPTIMISTIC PRAGMATIC | | |
| A. CAUSAL CONDITIONS | | | | | | |
| 1. The young person is concerned about the bed wetting | NO | NO | YES | YES | YES/NO | YES |
| 2. The young person believes that he/she has the capacity to control the situation now | NA | YES, AT LEAST TO SOME EXTENT | NO | PERHAPS, TO SOME EXTENT | YES | NO |
| 3. The young person believes that he/she will one day be dry at night | NA | YES | NO | YES | NOT SURE | NOT SURE |

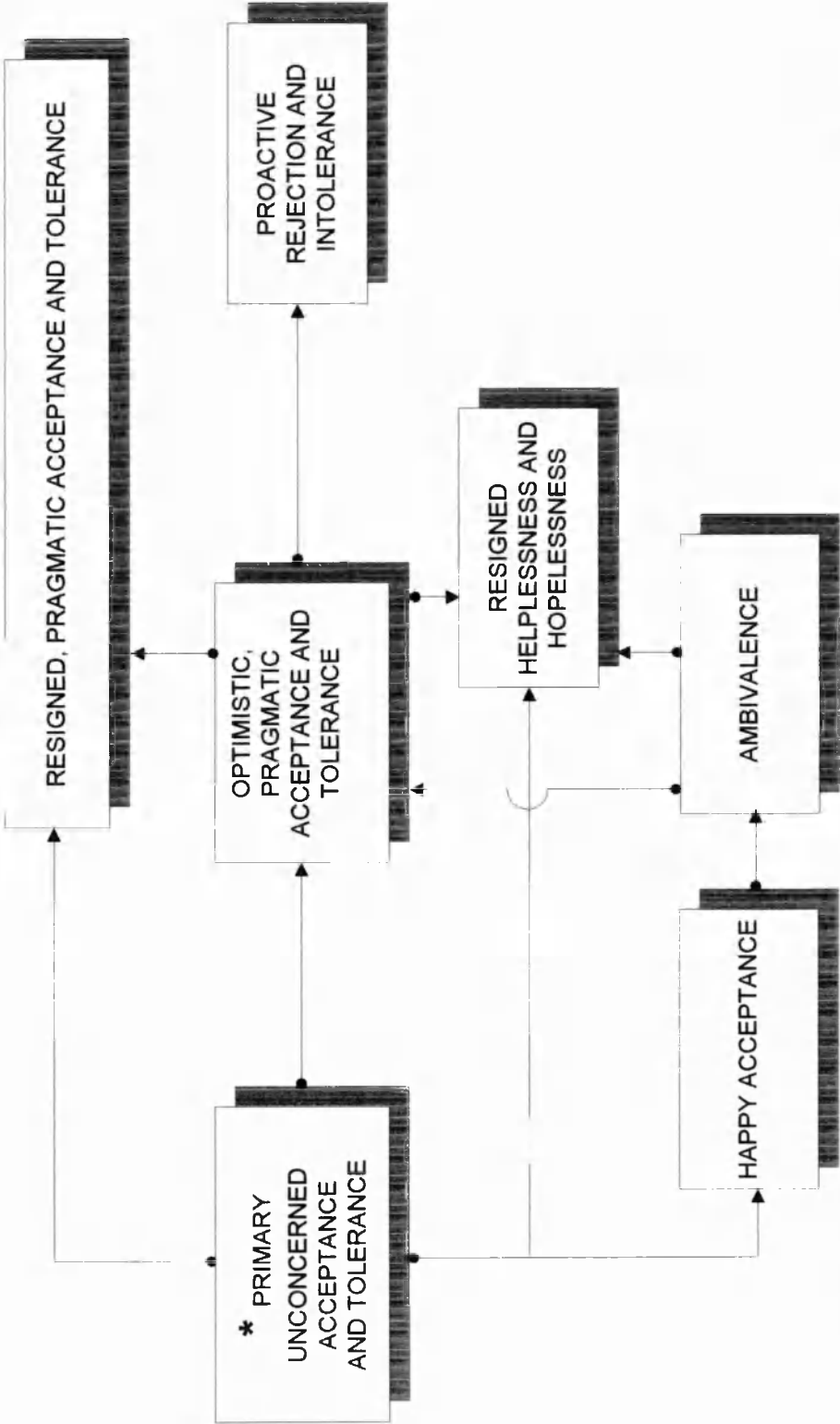
TABLE 17 continued

| YOUNG PERSON'S ATTITUDE | | | | | | | |
|--|---|---|----------------------------|----------------------|---|--|--|
| | ACCEPTANCE AND TOLERANCE | | | | AMBIVALENCE | PROACTIVE REJECTION & INTOLERANCE | RESIGNED HELPLESSNESS & HOPELESSNESS |
| | PRIMARY UNCONCERNED | HAPPY | RESIGNED PRAGMATIC | OPTIMISTIC PRAGMATIC | | | |
| B. <u>PHENOMENON</u> The young person's overall attitude to the bed wetting | Young person accepts and tolerates a situation which he/she believes: | | | | Young person has mixed feelings about a situation which he/she believes could perhaps be changed but which may bring benefits, if at some personal cost | Young person does not accept and is no longer prepared to tolerate a situation that he/she believes can be changed now | Young person is resigned to a situation that he/she believes cannot be changed now and is unlikely to change |
| | is not a problem | brings benefits, if at some personal cost | is unlikely to change ever | could change soon | | | |
| C. <u>INTERVENING CONDITIONS include:</u> | | | | | | | |
| 1. Young person's belief in his/her competence in other tasks | | | | | | | |
| 2. Attitude of parents towards the bed wetting | | | | | | | |
| 3. Attitude of health care professionals towards the bed wetting | | | | | | | |

TABLE 17 continued

| | YOUNG PERSON'S ATTITUDE | | | | | | |
|--|--------------------------|-------|--------------------|----------------------|------------------------------|-------------------------------------|--------------------------------------|
| | ACCEPTANCE AND TOLERANCE | | | | AMBIVALENCE | PROACTIVE REJECTION & INTOLERANCE | RESIGNED HELPLESSNESS & HOPELESSNESS |
| | PRIMARY UNCONCERNED | HAPPY | RESIGNED PRAGMATIC | OPTIMISTIC PRAGMATIC | | | |
| D. <u>INTERACTIONAL STRATEGIES</u> 1. Accepts responsibility for learning to be dry at night, when treatments are available | NA | NO | NA | YES | PERHAPS | YES | PERHAPS, BUT HALF-HEARTEDLY |
| 2. Persists with treatment and regards failures as temporary set backs | NA | NO | NA | YES | NO | YES, VERY PERSISTENT AND DETERMINED | NO, EASILY DISCOURAGED |
| E. <u>CONSEQUENCES FOR YOUNG PERSON</u> 1. Feelings, in relation to bed wetting episodes | Unconcerned | Happy | Very sad | Sad, at times | Mixed feelings, sad at times | Angry, at themselves | Very sad |
| 2. Feelings of shame associated with the bed wetting more generally | NO | NO | YES | YES | YES | YES | YES |

FIGURE 21 Young people's changing attitudes towards their bed wetting
(see Table 17 and Section 6.4.2)



Notes:

- * The young person may take any one of many routes originating from an attitude of primary unconcerned acceptance and tolerance of lack of bladder control. Other routes may be possible

It is suggested that some young people vacillate between two perspectives, for instance between optimistic pragmatism and resigned helplessness and hopelessness, in response to their evaluation of the success or otherwise of new initiatives to encourage the bed wetting to stop, which are usually undertaken at the parents' instigation. However, the attitudes of most young people appeared to have been consistently held for prolonged periods, in contrast to the attitudes of most parents which seemed more amenable to change.

It is suggested that the difference in the stability of young people's and parents' attitudes is a reflection in part of the difference in the amount of control that young people and their parents perceive themselves to be able to exercise over their lives more generally and their differing access to strategies to help to overcome the situation.

Each of the attitudes summarised in Table 17 is described below, with illustrations from the young people's own accounts of their beliefs, feelings (Table 18) and behaviour, supported by secondary evidence from parents in some cases. Where terms such as "acceptance", "tolerance" and "rejection" have already been defined for parents (Section 6.3.2) the same definitions are applied to the situations relating to the young people's attitudes.

Acceptance and tolerance

Four categories of acceptance and tolerance, summarised in Table 17 are described below.

Primary unconcerned acceptance and tolerance

Primary unconcerned acceptance and tolerance is defined as acceptance and tolerance of a situation that the young person has not yet come to recognise as being a cause for concern. This attitude is described as primary because it is contended that young people do not begin life with feelings of shame about lack of bladder control but have to learn from others that wetting the bed is socially unacceptable behaviour (Section 6.5.2). It is acknowledged that in very young children there is a stage which precedes this, when the child is not aware of "self" (Hetherington and Parke, 1993; Mussen et al, 1990).

TABLE 18 **How the young people felt about bed wetting and waking up to a wet bed**

| A G E | FREQUENCY OF BED WETTING ^c Usual ^d Diary ^e | YOUNG PERSON'S FEELINGS ABOUT BED WETTING | | | | | | NOT ASKED | YOUNG PERSON'S FEELINGS ON WAKING UP TO A WET BED | | | | | | NOT ASKED |
|----------------------|--|---|----|---|---|---|---|--------------|---|---|---|---|---|---|--------------|
| | | 😊 | 😊 | 😊 | 😊 | 😊 | 😊 | | 😊 | 😊 | 😊 | 😊 | 😊 | 😊 | |
| CAROL | 17 | 7 | 5 | | | | | | 😊 | | | | | | 😊 |
| ANTHONY | 16 | 6 | 2 | | | | | | 😊 | | | | | | 😊 |
| PETER | 15 | 6 | 5 | | | | | | 😊 | | | | 😊 | | |
| ROGER | 14 | ≤1 | 0 | | | | 😊 | | | | | | 😊 | | |
| PAUL | 13 | 3 | <1 | | | | | | | | | 😊 | | | |
| IAN | 13 | ≤1 | 1 | | 😊 | | | | | | | 😊 | | | |
| SARAH | 11 | 6 | 5 | | 😊 | | | | | | | | | 😊 | |
| JENNIFER | 9 | 4 | 3 | | | | | | 😊 | | | | | 😊 | |
| ALISON | 9 | 7 | 2 | | | | | | 😊 | | | | | | 😊 |
| TRACY | 9 | 5 | NK | | | | | | 😊 | | | | 😊 | | |
| WILLIAM | 9 | 3 | 3 | | 😊 | | | | | | 😊 | | | | |
| MICHELLE | 8 | ≤1 | NK | | | | | | | | | | | 😊 | |
| SIMON | 8 | 2 | NK | | | 😊 | | | | | | | 😊 | | |
| STEPHEN ^a | 8 | 7 | 6 | | | | | | 😊 | | | | | 😊 | |
| JOHN ^a | 8 | 3 | 2 | | | | | | 😊 | | | | | 😊 | |
| MICHAEL ^b | 8 | 7 | 7 | | | | | | | | | | | 😊 | |
| SHELLY | 7 | 7 | 5 | | | | | | 😊 | | | | | 😊 | |
| MARTIN | 6 | ≤1 | 0 | | | | | | | | 😊 | | | | |
| GARY | 5 | 7 | NK | | | | | | | 😊 | | | | | |
| LISA | 4 | 7 | 6 | | | | | | | | | | | 😊 | |

Notes: ^a twins ^b chronic renal failure ^c nights per week ^d from urinary symptom questionnaire ^e from diary NK: diary not kept and not known

Happy acceptance and tolerance

Happy acceptance and tolerance is defined as acceptance and tolerance of a situation that the young person has discovered brings with it some secondary benefits, if at some personal cost. Butler (1987) suggests that deliberate bed wetting is rare. In the present study there was some evidence to suggest that Gary was wetting the bed deliberately and that Michelle had wet the bed deliberately on some occasions in the past.

The parents of both these children said that they had observed the child to wet the bed while awake. Gary's mother had attributed her son's behaviour to his desire to retaliate when his father was angry with him over other issues (Section 6.3.2). Gary was the only young person to indicate that he felt happy when he woke up to find the bed wet by ticking a smiling face on a faces-feelings card (Table 18) and he confirmed this in conversation alone with the researcher:

"MOYA: Do you ever wet the bed?

GARY: Sometimes.

MOYA: Sometimes. And how do you feel about that?

GARY: Fine.

MOYA: You feel fine about it - you don't mind about it?

GARY: No."

Gary (age 5) 3211/7 p.3

When asked if there were any bad things about wetting the bed, he replied: "getting skelped". Gary was consistently blamed for bed wetting and was often punished for it (Section 5.5.3). He did not however appear to be ashamed of the bed wetting. Gary was a secondary bed wetter (Section 4.3).

The only other young person where there was the hint of happy acceptance of wetting the bed in the past was Michelle. In the past Michelle's mother had found her wetting the bed when awake (Section 6.3.2). Michelle appeared to have a poor relationship with her mother and she was often punished for bed wetting. At the time of the study Michelle said that she was sad about the bed wetting because of the smell and because she sometimes developed a rash. She ticked an unhappy face (Table 18) to describe how she felt when she found that the bed was wet:

"MOYA: Tell me why that one.

MICHELLE: Because I want to get it over and done with.

MOYA: I'm sure.

MICHELLE: Because I don't like the bed wetting any more. Because when some people come to stay with me they'll find out."

Michelle (age 8) 3211/23 p.2

Michelle's comments suggest that she had learned to be concerned about the bed wetting and wanted it to stop for social reasons. One of the greatest concerns of young people about their bed wetting was discovery by peers (Section 5.3.2).

Resigned pragmatic acceptance and tolerance

Resigned pragmatic acceptance and tolerance is defined as acceptance and tolerance of a situation which the young person believes cannot be changed now and is highly unlikely to change ever. This attitude is described as pragmatic and resigned because the young person has realistically given up hope of becoming dry at night.

The young person is not blamed by his parents for behaviour which is recognised as being beyond his control but the young person nevertheless feels very sad and perhaps ashamed about his lack of ability to do what other young people can do. In this study there was only one young person who fell within this category, Michael, who had been diagnosed as having only one, partially functioning kidney shortly after birth. Michael was very sad about the bed wetting (Table 18) but in a rather different way from the other young people, as he explained when he described his picture of himself on a wet morning:

MOYA: And how do you feel?

MICHAEL: Sad about it. I actually feel kind of silly at times.

MOYA: Why is that?

MICHAEL: Because I think to myself - I can't do some of the things normal boys do."

Michael (age 8) 3211/55 p.3

To Michael wetting the bed was an indication that he was different from other children.

Optimistic pragmatic acceptance and tolerance

This attitude is defined as acceptance and tolerance of a situation which the young person believes could change soon. This attitude is described as optimistic and pragmatic because the young person believes that he is capable of achieving dry nights but is realistic that the achievement of this goal is unlikely to happen overnight or without effort.

For the most part these young people believe that their parents do not blame them or no longer blame them for wetting the bed but they do recognise that their parents are at times frustrated and angry about having to manage the consequences arising from the wet bed, especially the extra laundry.

At the time of this study nine young people seemed to have adopted this attitude. However in only two cases did it appear that this attitude had been consistently held over a prolonged period.

Although neither boy liked waking up to a wet bed, William and Ian seemed to be the least concerned about the bed wetting (Table 18). All the young people in this group were wetting the bed three nights per week or less at the time of their conversations with the researcher and could see from their own experience that dry nights were possible, even if these were not always perceived to be directly linked to their own efforts.

Outward acceptance of the situation should not be taken to mean that these young people do not feel sad and ashamed about the bed wetting on occasion, in response to the negative remarks of others, especially their peers (Section 5.3):

"ROGER: It hurts me sometimes ... You get used to it."

Roger (age 14) 3211/44 p.1

Anthony seemed to vacillate between optimistic pragmatism and resigned helplessness and hopelessness. During this study the frequency of his bed wetting fell quite markedly (Appendix XIV) and he seemed optimistic and philosophical on speaking with the researcher after the diary keeping:

"ANTHONY: It's like sort of restrictive. I don't really class it as anything wrong, but it's just something I have to live with."

Anthony (age 16) 3211/3 p.1

However Anthony's mother remarked that she had overheard her son talking to his younger sister Susan about his feelings:

"MRS A: Anthony's comment to Susan (his sister) was, 'a three year old can do it and I can't. How'd you feel about that? How do you think I feel when a three or four year old child can be dry?' - and it was from the heart."

Mother of Anthony (age 16) 3211/55 p.1

Both Anthony and Roger had learned ways of coping with the bed wetting, at least outwardly. There was little doubt however, that both of these young men were ashamed of bed wetting and that this had at times affected their self-esteem.

Some of the young people denied at first that they had much of a problem with their night time bladder control:

"JOHN: Before Christmas - I never wet until Christmas - well, last year I wet once because I was too excited. That was why I wet at Christmas. I was too excited.

MOYA: Too excited. Any other times when it happens?

JOHN: When it's my birthday."

John (age 8) 3211/117 p.1

According to his urinary symptom questionnaire and diary John was actually wetting the bed two or three nights a week (Appendix XIV).

As discussed for instance by Lazarus(1991) and by Weiner (1992) it is commonplace for people who perceive themselves to have failed to achieve a personal ideal to desire to avoid having this failure observed by others. Feelings of shame lead to attempts to hide the failing from public exposure as the expectation is that others will disapprove, leading to a further lowering of their self-esteem (Section 6.5.2).

Ambivalence

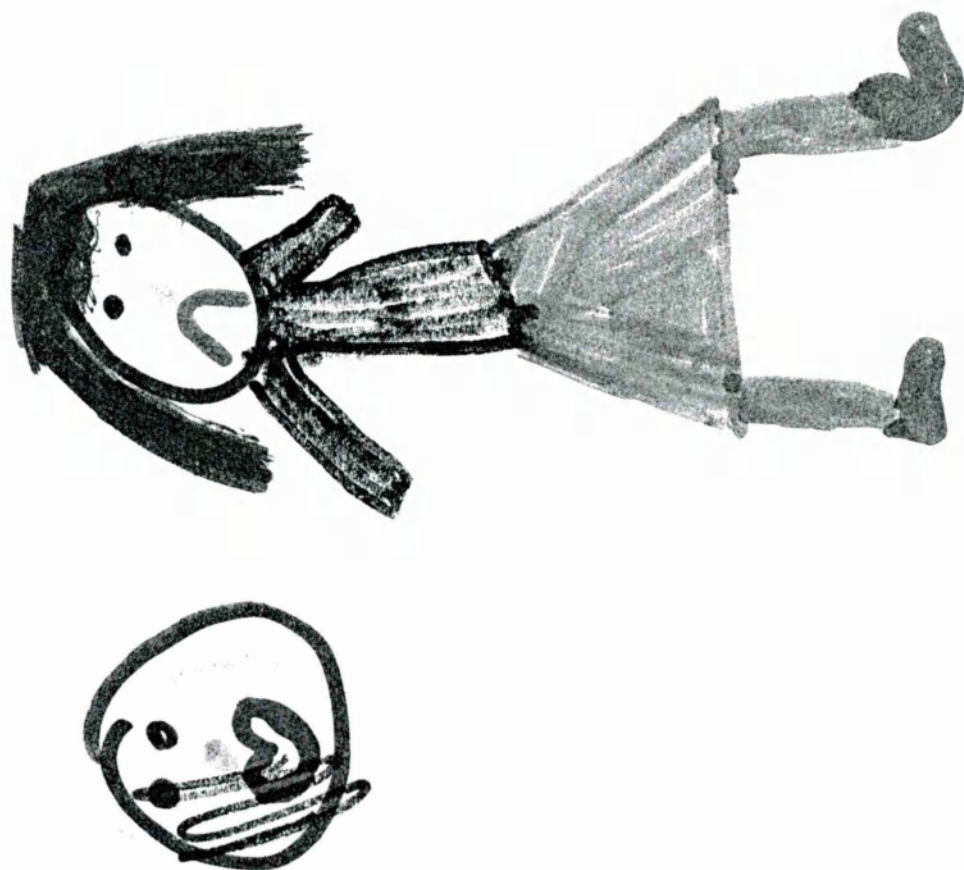
This attitude is defined as having mixed feelings about a situation which the young person believes could perhaps be changed but which he or she has discovered brings with it some benefits, if at some personal cost.

It was difficult to be sure what Sarah and Tracy felt about their bed wetting. Both seemed to be ambivalent about it. Both found it difficult to talk about their feelings. When asked to draw a picture of themselves on waking up in the morning to find themselves wet, both at first drew a happy face and then changed it. Tracy's picture of herself is given at Figure 22. When asked who the smiling face belonged to she replied:

"TRACY: That was me, but I did it wrong ... I meant to do it sad, but I done it happy."

Tracy (age 9) 683/65 p.8

FIGURE 22 Tracy's drawing of herself on waking up to find a wet bed (age 9)



Sarah also altered her picture of herself on a wet morning. Her mother pounced on this "mistake" immediately and said it was "highly significant". She said that she felt that Sarah had far more control over the situation than she "let on" (Section 6.3.2).

Whether or not Sarah or Tracy received any secondary benefits from wetting the bed, in terms of extra attention or were merely reluctant on some occasions to get out of a warm bed to go to the toilet is not known, but both girls appeared to be unhappy and both mothers described their relationships with their daughters as problematic. Tracy's mother described her daughter as "deep":

"MRS T: She kind of keeps things in, ken, she'll no' communicate, ken - she'll just no' sit and talk to you."

Mother of Tracy (age 9) 681/3 p.1

Both Sarah and Tracy were living in households where conflict with their parents was common, and where they were consistently blamed and punished for their failure to fulfil their parents' expectations of them (Section 5.5.3). As described in Section 6.3.2 both parents seemed to be saying to their daughters that they could act differently.

Pro-active rejection and intolerance

This attitude is defined as a refusal to accept and tolerate a situation which the young person believes is within his control, given sufficient effort. The attitude is described as pro-active because the young person accepts responsibility for the situation, persisting with treatment and perhaps even taking the initiative when new opportunities arise to enable the bed wetting to stop. The young person is determined to resolve the problem and is angry with himself for the continuance of a situation which it is believed could by now have been resolved with more effort. The continuance of the problem leads to a reduction in the young person's self-esteem, which may in these cases, be a potent driving force for seeking a solution.

Two young people seemed to have adopted this attitude, Simon and Paul. Both appeared to be acutely embarrassed about the bed wetting and to want it to stop. The parents of both Simon and Paul were supportive of their sons' efforts to be dry.

Simon had been making a consistent effort to be dry at night for some time before the study and he achieved two weeks of dry nights between completing the urinary symptom questionnaire and the first (and only) visit by the researcher, in spite of the fact that he had stopped taking Desmospray (Appendix XIV). In his picture of himself on waking up to find the bed wet (Figure 23) he included his star chart on which he had faithfully marked his progress towards his goal of becoming dry. The inclusion of the star chart was unsolicited. When asked what his picture meant, he replied:

"SIMON: I'm annoyed I'm wet."

Simon (age 8) 621/77 p.10

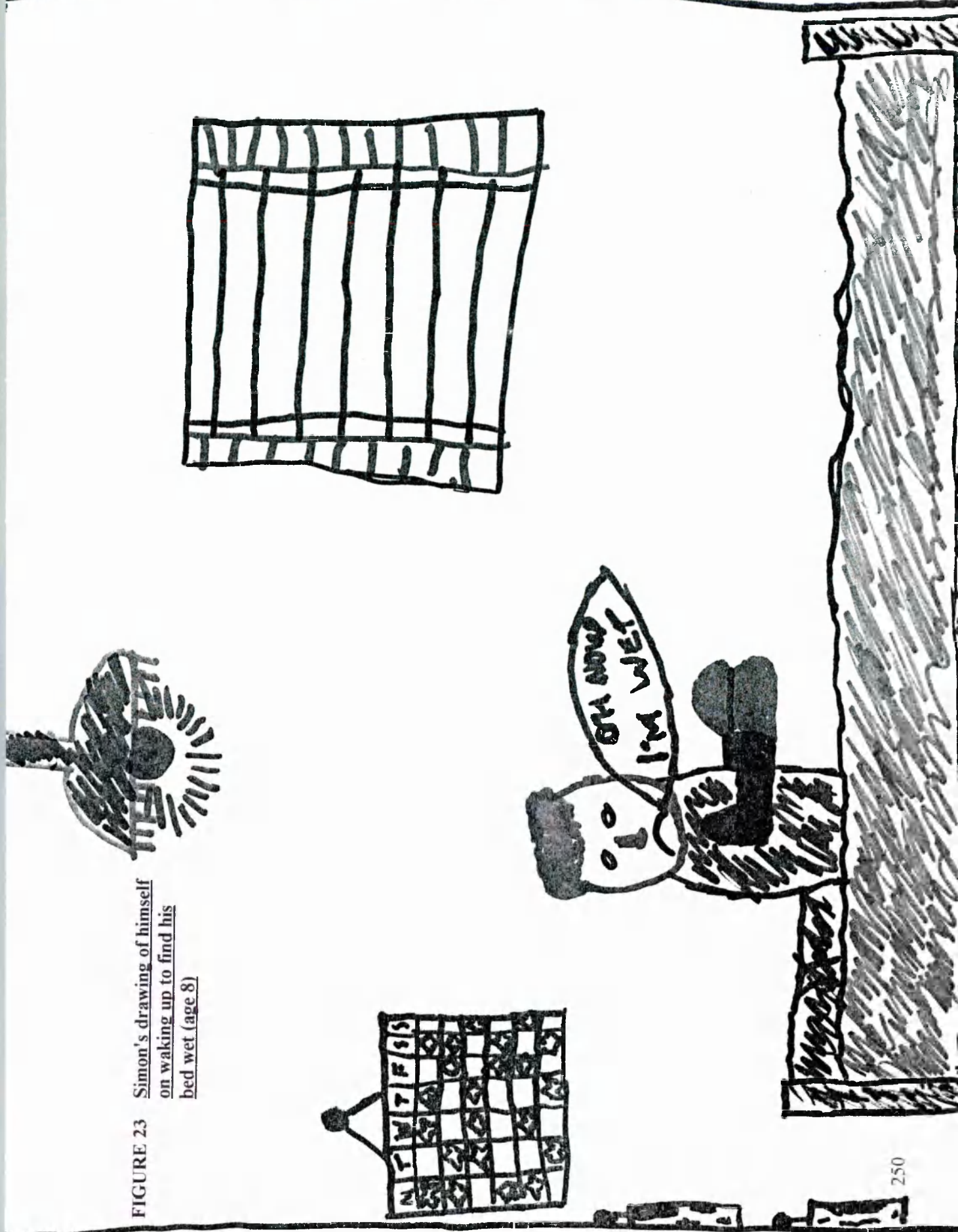
Simon seemed particularly determined to be dry and his mother was both optimistic, pragmatic and supportive. She said that she did not believe in punishment and she had discovered that even the use of small rewards had put too much pressure on Simon to be dry at times. She had discontinued using a rigid system of rewards which Simon had been unable to attain (Section 5.5.2).

Paul was one of the most reluctant young people to speak with the researcher and appeared to be acutely embarrassed about the situation. Although he had agreed to the meeting when his parents had discussed this with him, he took the long way home from school on the day that the meeting was scheduled and hid behind the door of the room where the meeting was taking place.

Paul's father had encouraged him to take responsibility for the situation. He described his son as "fed up" with the bed wetting. Before the study Paul had taken responsibility for an alarm clock method which seemed to have worked well for him (Section 5.5.1). This method had been suggested by a hypnotherapist.

Paul did not keep the study diary, but according to his father's Filofax he only wet the bed on three out of the 28 nights following the first meeting with the researcher. In each case there was said by his father to be mitigating circumstances. The researcher was left with the impression that Paul was angry that he had been involved in the study. According to the urinary symptom questionnaire he had been wetting the bed three nights a week on average but this had reduced to less than once a week during the time when the diary would have been kept. It was discovered eight months later, when his mother wrote to the researcher (Section 3.7.2.4) that Paul had become reliably dry shortly after his first meeting with the researcher, much to the delight of everyone in the family.

FIGURE 23 Simon's drawing of himself
on waking up to find his
bed wet (age 8)



This could have happened purely by chance, as 15% of young people become spontaneously dry every year (Section 2.2.2). Paul clearly wanted the bed wetting to stop and had accepted responsibility for helping it to stop. This may have contributed to his ultimate success. The theme of perceived control is further explored in Section 6.6.

Resigned helplessness and hopelessness

This attitude is defined as accepting with sadness a situation which the young person believes is outwith his or her control and is unlikely to change.

Unlike resigned pragmatism, the young person believes himself to be responsible and to be held responsible by one or both parents for a situation which he believes himself to be unable to influence, in the light of repeated failure to achieve dry nights, however hard he has tried in the past.

If these young people do engage in treatment suggested by others, their efforts are at best half-hearted and they are easily discouraged and give up quickly in the face of failure. They come to believe that any dry nights that they do experience are due to chance and they are ashamed that they cannot achieve an "easy" task, which most three year olds can accomplish (Section 6.6.1). Their lack of belief in their ability to influence the situation and their lack of action is often interpreted by parents as a lack of concern about the bed wetting accompanied by a lack of effort to help themselves (Section 6.5.3). They therefore perceive themselves to be, and are sometimes, blamed for doing too little to help themselves and they may have been punished in the past for their failure to comply with the behaviour expected by others.

In all, four young people were deemed to have this attitude at the time of the study and they ranged in age from 4 to 17 years. For a further three young people this seemed to have been their predominant attitude towards the bed wetting until the time of the study when they experienced that dry nights were possible. All seven of these young people had been wetting the bed on six to seven nights per week. All of these young people had also had problems with day wetting. This group included the four young people who had a day wetting problem "very often", with the urine usually leaking to the outside of their clothes (Table 9, Section 4.3.3).

Six of the seven had had a day wetting episode at school and in four cases this had been recent (Appendix XIV). This group therefore included some of the most severely affected bed wetters, most of whom had had to live with the double disadvantage of lack of day time bladder control.

Carol was sad and frustrated about the bed wetting and clearly wanted it to stop (Figure 24). She was, however, pessimistic about the future:

"MOYA: When do you think you're going to be dry? Have you got any ideas?

CAROL: No.

MOYA: No idea when it's going to happen?

CAROL: I'll just have to wait.

MOYA: You said when I spoke to you last, 'if I ever become dry', do you think you will become dry?

CAROL: Hopefully, yes. But doubtfully, no."

Carol (age 17) 332/68 p.1

Carol had tried many treatments but nothing had worked for her. There was evidence to suggest that her attempts to become dry, at least latterly, had been at best half-hearted (Section 5.6.1). Carol had suggested that the bed wetting might be due to bad luck (Section 6.4.1) or to something "in the mind". Carol's mother had wet the bed herself until she was 16 years of age and her father had wet the bed until he was 24 years old. This could well have affected Carol's expectancy that dry nights were possible.

Peter and Shelly also each had a parent who had not been dry until the age of 15 years. Peter had come to believe that he was unable to be dry, he therefore expected failure and he felt ashamed at his lack of ability to do what his two and a half year old half brother could do (Section 6.5.3).

Shelly, like Peter, was very sad about the bed wetting (Table 18) and wanted it to stop. Although Shelly was wetting the bed every night of the week, according to her urinary symptom questionnaire, and the first three weeks of her diary (Appendix XIV), her parents had bought her a new bed at the time that they bought new beds for everyone else in the family and, as the diary records, Shelly then had six dry nights in a row. Her mother seemed genuinely astonished:

"MRS S: I just couldn't believe it when she stopped wetting ... she's been great."

Mother of Shelly (age 7) 1211/1 p.18

FIGURE 24 Carol's drawing of herself on waking up to find her bed wet (age 17)



The bed had not been purchased with the intention of motivating Shelly to be dry or with any expectation that dry nights would result. However, Shelly may have taken the purchase of the new bed to be an indication that her mother thought that she was capable of achieving dry nights. She beamed with pleasure as she shyly told the researcher how many dry nights she had achieved in the week before the researcher's return visit.

At the start of this study Alison was obviously both sad and ashamed about wetting the bed. As she ticked the very sad face on a faces/feelings card (Table 18) two big tears came into her eyes and she could not speak. The topic of bed wetting was discontinued at once.

Alison had wet the bed almost every night for the previous seven years. Her mother had given up hope that she would ever be dry and had finally taken the conscious decision to do nothing more as everything that she had tried had failed (Section 6.3.2). However Alison meticulously kept the study diary, under her mother's supervision and with both parents' encouragement, and she began to experience more and more dry nights (Appendix XIV). Through the diaries Alison came to see that she could be dry. She began to feel more in control of the situation and her feelings became much more positive as did the feelings of the whole family. This was reflected in the mother's diary. The entries for three mornings are given below:

"Saturday, 26 March: Alison a bit teary this morning and a bit upset with J (her stepfather). Not a good day for her but at least she does try.

Wednesday, 30 March: We're all very pleased that Alison is dry this morning. It just sets the day up the right way for us all.

Wednesday, 6 April: Alison is dry again. This is the 6th morning she has been dry and over the moon. Her chart has gave her a lot of confadense [sic]."

Extract from Alison's mother's diary, kept during the study.

These extracts show the effects of bed wetting or a dry bed on the young person's feelings and behaviour in the morning, and the difference in the atmosphere within the household when the young person is dry. This is a clear illustration of mutual simultaneous shaping. Alison's mother commented on the difference in her daughter's behaviour in the mornings:

"MRS A: If she's dry now she'll come through running, 'I'm dry this morning!' - fairly proud of herself. When she's wet, she'll no' mention it - sometimes she'll say, 'I don't know', and she'll go back and checks and comes back. If she says 'I don't know', it usually means 'aye', when she tries to hide it."

Mother of Alison (age 9) 125/31 p.2

The above quotation illustrates the young person's pride in her achievement when dry, which she attributed to her own efforts and her feelings of shame when she could not live up to her own ideal, which she tried to hide.

Both Stephen and Lisa wet the bed seven nights per week and this continued to be the pattern for them throughout the study. Both young people were very sad (Table 18) and embarrassed about their bed wetting and this showed in their non-verbal as well as their verbal behaviour.

After a lively conversation which had preceded the first question about bed wetting, Lisa (age 4) became very subdued and of her own accord went to sit on her mother's lap and snuggled in for a cuddle. Lisa's parents confirmed how sad their daughter was about the bed wetting and how much she wanted it to stop:

"MR L: She's awfy embarrassed aboot it, you know ... I just ken by her face, you know ... it's just the first maybe 10 minutes every morning, she'll be quiet and that is - that is just no' Lisa and she's - she's just a riot a' the time - she's 100 miles an hoor."

Father of Lisa (age 4) 1241/3 and 29 p.2

As with Alison, Lisa's parents clearly described the difference in their child's behaviour on wet and dry mornings. Although she was only four years old, Lisa had learned that bed wetting was unacceptable behaviour. Her parents had punished her for it until they had come to realise that it was not her fault (Section 5.5.3). She had perceived that her bed wetting was also disapproved of by wider family as well, when she had experienced a loss of night time bladder control when staying away from home (Section 5.4.2).

In summary, most young people are sad and ashamed about wetting the bed and want it to stop.

The concepts of perceived helplessness and perceived control are discussed in depth in Section 6.6.

6.5 The social origins of parents' and young people's beliefs and attitudes towards bed wetting

6.5.0 Introduction

This section is about the social origins of parents and young people's beliefs and attitudes towards bed wetting (Sections 6.5.1 and 6.5.2). The way in which parents' and young people's attitudes can be reinforced, as family members interact from day to day, is described in Section 6.5.3.

Social psychologists suggest that people are not born with beliefs and attitudes, although they may be born with a genetic predisposition towards them (Baron and Byrne, 1994). It is thought that beliefs and attitudes are gradually acquired or learned, for the most part, from authoritative figures such as parents and teachers (Section 6.2.2.1). This is sometimes referred to as social learning:

"Children learn from parents not only what objects *are* but what one should *believe* and *feel* about them and how one should *act* toward them"

Bernstein et al (1991) p.687

Social learning occurs in several ways, which include:

- **classical conditioning** - learning based on association
- **instrumental conditioning** - learning in which responses that lead to positive outcomes (or permit avoidance of negative outcomes) are strengthened
- **modelling** - learning by example

(Baron and Byrne, 1994; Stahlberg and Frey, 1994; Stroebe and Jonas, 1994). Learning can occur even when parents have no desire to transmit specific views to their children who, nevertheless, learn through observing their parents' behaviour. Children may carry many of their attitudes with them into parenthood.

Beliefs and attitudes are also acquired from direct personal experience. Research suggests that attitudes learned in this way are more confidently and consistently held and are more resistant to change than attitudes borrowed from others (Baron and Byrne, 1994).

6.5.1 The social origins of parents' beliefs and attitudes towards bed wetting

It is not possible to know the myriad situations and experiences which have contributed to a person's beliefs and attitudes, however some of the possible sources of parents' beliefs and attitudes towards bed wetting are suggested in Figure 25. These sources are briefly commented upon below.

Prevailing social-cultural beliefs and the beliefs and attitudes of wider family and friends

Irrespective of their own beliefs and attitudes towards their child's bed wetting, all the parents in this study believed that there were many people outwith the family, living in the local community and the wider society (Figure 9), who disapproved of bed wetting in children over a certain age. In many cases this belief was born of or confirmed by experience, when their child's bed wetting was discovered by others (Section 5.4).

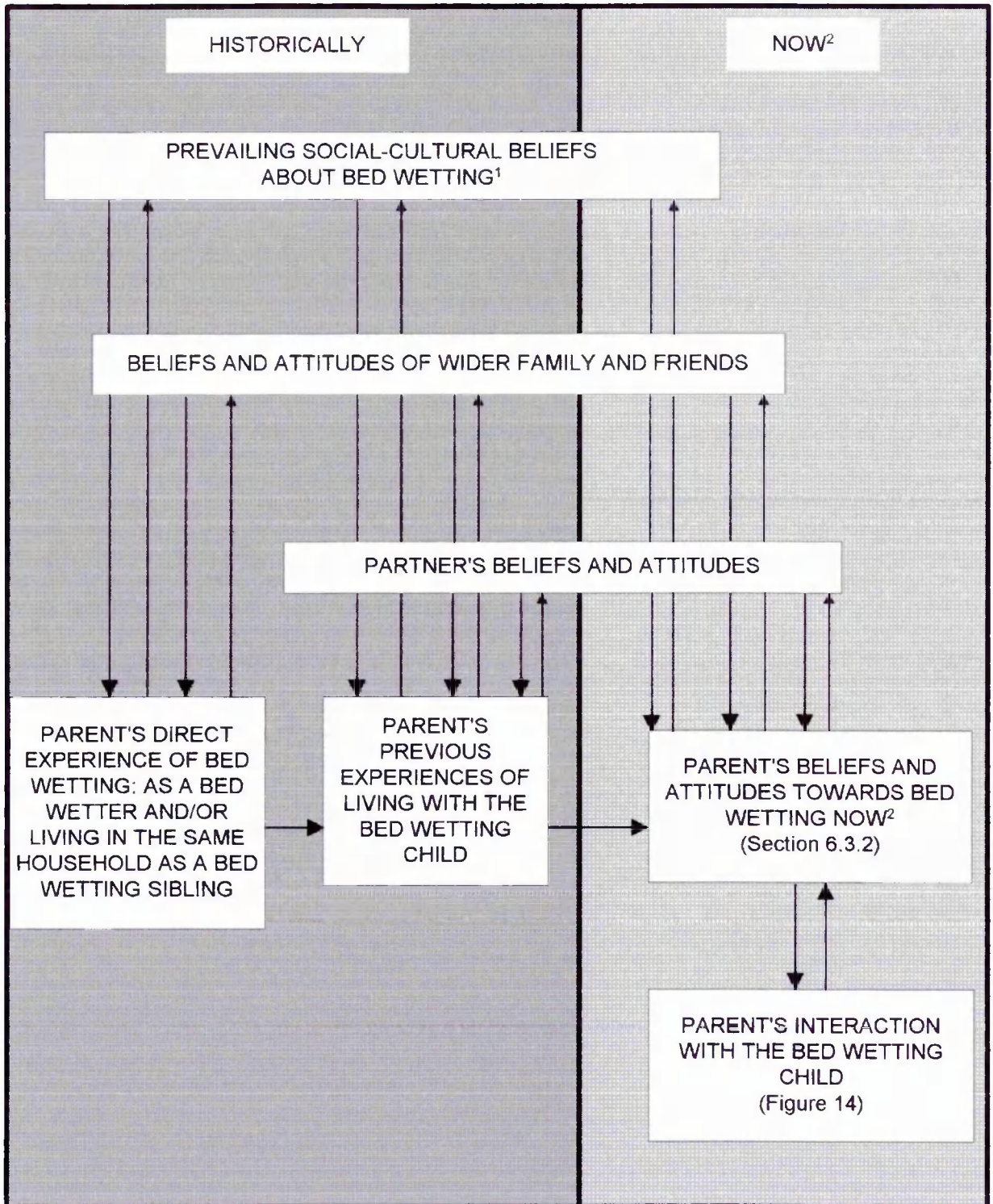
Parents gave the disapproval of others as the main reason for their unease about letting the young person stay away from home (Section 5.4.2). In practice some of the parents' close relatives were accepting of the situation and were happy to have the young person to stay, but many were not (Section 5.4.3). Fear of discovery was acknowledged by many parents, as well as by the young people who wet the bed.

In his book: *Adult bed wetters and their problems*, Stone (1973, p.1) wrote:

"Even in these 'enlightened' times, it is commonly assumed that the complaint is somehow recriminatory on the sufferer."

In spite of the work of the Enuresis Resource and Information Centre (ERIC), initiatives of the Association for Continence Advice (ACA) and others, lack of bladder control can lead to feelings of shame in people of whatever age in response to the attitudes of others (Section 2.2.4). Most parents in this study did not perceive the attitude of others to be accepting or empathetic towards their child's bed wetting.

FIGURE 25 Some possible sources of a parent's beliefs and attitudes towards bed wetting



Notes:

1. Through the media of books about bed wetting written by health care professionals and others, magazine articles, television and radio, as well as handed down "common sense" knowledge of what is developmentally "normal" for young people of different ages.

2. "Now" is taken to mean "at the present time ...in the present circumstances, as things are;" The Chambers Dictionary (1994) p.1156. "The present circumstances" may be today, for the past month, for the past year, or as it has always been with this child if nothing has changed.

There was some evidence to suggest that parents' attitudes were similar to their own parents' attitudes towards bed wetting, that is there seemed to be an intergenerational tendency towards either acceptance or intolerance of it (Section 5.4.3).

Partners' beliefs and attitudes

In most families the parents expressed broadly similar views about the young person's bed wetting, although many mothers commented that their husbands tended to be or to have been less tolerant of it than they were themselves (Section 5.2.2).

Parents described differences in their attitudes towards the use of punishment, with fathers tending towards a more punitive approach (Section 5.5.3) which had caused tension in some families (Section 5.4.1).

There is some evidence that a mother's attitude towards her child's bed wetting is influenced by her perception of herself in the role of "mother" and the expectancy of others of her in this role (Section 5.2.1). Some mothers may have persuaded their husbands into adopting a more accepting attitude than they naturally felt. In many cases the father had little to do with the young person's bed wetting in the practical sense and many of these fathers appeared to be deferring to their wives' views and wishes about how the situation should be managed (Section 5.2.2). In this sense the mother seemed to be orchestrating the views of both parents in the family so that, for the most part, they both sang the same tune (Section 5.2.1).

In three cases however, the father had clearly abdicated responsibility for any involvement in the management of the bed wetting and these mothers were effectively left to cope alone (Section 5.2.2). These fathers were sending a clear message to their wives and children that the bed wetting was unacceptable. Whether or not these mothers felt blamed for the young person's lack of bladder control is not known.

In two families the mothers expressed mixed feelings about their sons' bed wetting in the light of their husbands' assertion that these adolescents had more control over the situation than they were choosing to exercise (Section 6.3.2). Fathers may have more influence over the social environment created within the home for the young person to learn to be dry at night than has hitherto been realised. When assessing families it would seem prudent not to ignore the fathers' views (Chapter 7).

Experience of being a bed wetter or living with a bed wetting sibling

A parent's experience of being a bed wetter or of living with a bed wetting sibling seemed to have a powerful influence on the parents' attitudes and beliefs about their own child's bed wetting. Mothers who had been bed wetters themselves seemed to be particularly accepting of the young person's bed wetting while some fathers who had been bed wetters were not (Section 5.2).

When discussing the methods that they had adopted to encourage the young person's bed wetting to stop (Section 5.5) several of the mothers who had themselves been bed wetters commented that they were only doing with their children what their mothers had done with them:

"MRS J: We had the buzzer. She (her mother) used to lift and lay us too. We weren't allowed drinks. It's only doing like what my mum did with us, really."

Mother of John and Stephen (age 8) 13311/39 p.1

The decision of mothers not to punish their child for bed wetting was also said to be a reflection of their own experience in some cases (Section 5.5.3). These mothers did not punish their children either because they had not been punished themselves or because they had seen from their own experience that punishment did not hasten the achievement of dry beds. Several mothers who had not been bed wetters commented that they did not believe in the use of punishment as a matter of principle, rather than from experience.

Mothers who had personal experience of bed wetting were among the most optimistic that the young person would one day be dry, because they knew from their own experience that they themselves had become dry, and they were among the most accepting and pragmatic of all parents in the meantime (Section 6.3.2). There was, however, the suggestion that at least one mother had made very little effort

on her child's behalf because she did not regard the bed wetting as a problem (Section 5.5). It may also be that she did not regard bed wetting as particularly amenable to treatment as a result of her own experiences as a bed wetter until the age of 15 when the bed wetting was said to have spontaneously resolved.

Previous experience with this young person

A parent's previous experience of the bed wetting of their own child, discussed throughout Chapters 5 and 6, appeared to be a particularly important determinant of their expectancy of a successful outcome and of their feelings of control. The parents of seven young people who were wetting the bed six to seven nights per week and for whom many treatments had failed (Sections 5.5 and 5.6) were among the most pessimistic about the outcome in the longer term and about their own ability to influence the situation, and understandably so. The consequences of parents' experiences with their own child for their attitudes towards bed wetting are highlighted in Section 6.3.2.

Predispositional tendencies towards certain attitudes

There is a small but growing body of evidence to suggest that genetic factors can play a part in attitude formation (Baron and Byrne, 1994; Plomin, 1994). Individuals may be born with a tendency towards optimism or pessimism, tolerance or intolerance, and feelings of competence or helplessness. A discussion of the influence of a parent's personal traits on his or her evaluation and interpretation of events is only touched upon, yet it could be an important contributory factor.

6.5.2 The social origins of young people's beliefs about bed wetting and about themselves as bed wetters

In this section it is argued that young people acquire their beliefs and attitudes towards bed wetting through a process of social learning, in much the same way that their parents have learned their beliefs and attitudes towards it (Sections 6.5.0 and 6.5.1).

Young people learn to feel ashamed of wetting the bed as a result of the negative evaluation of their behaviour by others, both within and outwith the family. As a result of repeated failure to accomplish a task believed to be within the capability of a three year old the young person's feelings of embarrassment and shame are reinforced and many young people come to believe that the outcome is not contingent upon their efforts (Section 6.6.1). Young people may be born with a disposition towards optimism or pessimism and with a belief in their own competence or helplessness to influence situations.

Learning to feel ashamed about wetting the bed

It is suggested that young people learn to feel ashamed of wetting the bed as a result of the negative evaluation of their behaviour by others, both within and outwith the family. Lazarus (1991, p.241) describes the antecedents of shame:

"Shame is generated by a *failure to live up to an ego-ideal*. We feel disgraced or humiliated, especially in the eyes of someone whose opinion is of great importance to us such as a parent or parent-substitute [e.g. teacher, health care professional, perhaps] ... In shame, another person whose approbation is important to us views and presumably is critical of our failure. We have, in effect, disappointed that person ..."

Weiner (1992) suggests that shame involves negative self evaluation and results from an internal ascription for some negative act or failure, leading to lowered self esteem.

Many parents described their children as embarrassed and ashamed about their bed wetting (Section 5.4) and most young people were fearful of the social consequences should their bed wetting be discovered by others (Section 5.3). Even the most accepting parents gave fear of the disapproval of others as the principal reason for their unease about letting the young person stay away from home (Section 5.4.2). It is suggested that these parents had sent the message to the young person: "We understand that you cannot help wetting the bed but there are people outwith the household who might disapprove. We don't want you to be hurt by the negative attitude of others". The young person does not need to experience disapproval directly to learn that bed wetting is regarded by some people as unacceptable behaviour after a certain age, however the data suggest that most young people had also

had direct experience of the disapproval of others, including wider family and friends and had in some cases been publicly humiliated (Sections 5.3.3, 5.4.2 - 5.4.4).

In some cases the source of disapproval was other family members. Young people's perception of their siblings' attitude to their bed wetting is described in Section 5.3.1. Often the siblings' evaluation was perceived by the young person to be negative, especially if the sibling shared a bedroom with the bed wetter.

It is suggested, however, that it is the parents' attitude towards the bed wetting, whether this is acceptance and tolerance or rejection and intolerance (Section 6.3.2) which is a particularly important determinant of the young person's attitudes towards bed wetting and towards himself as a bed wetter. Parents' disapproval was most clearly demonstrated by the consistent use of punishment for bed wetting (Section 5.5.3).

An observation made in this study was that families varied in the consistency with which the young person's bed wetting was negatively evaluated by members of the same household, as illustrated in Figure 26.

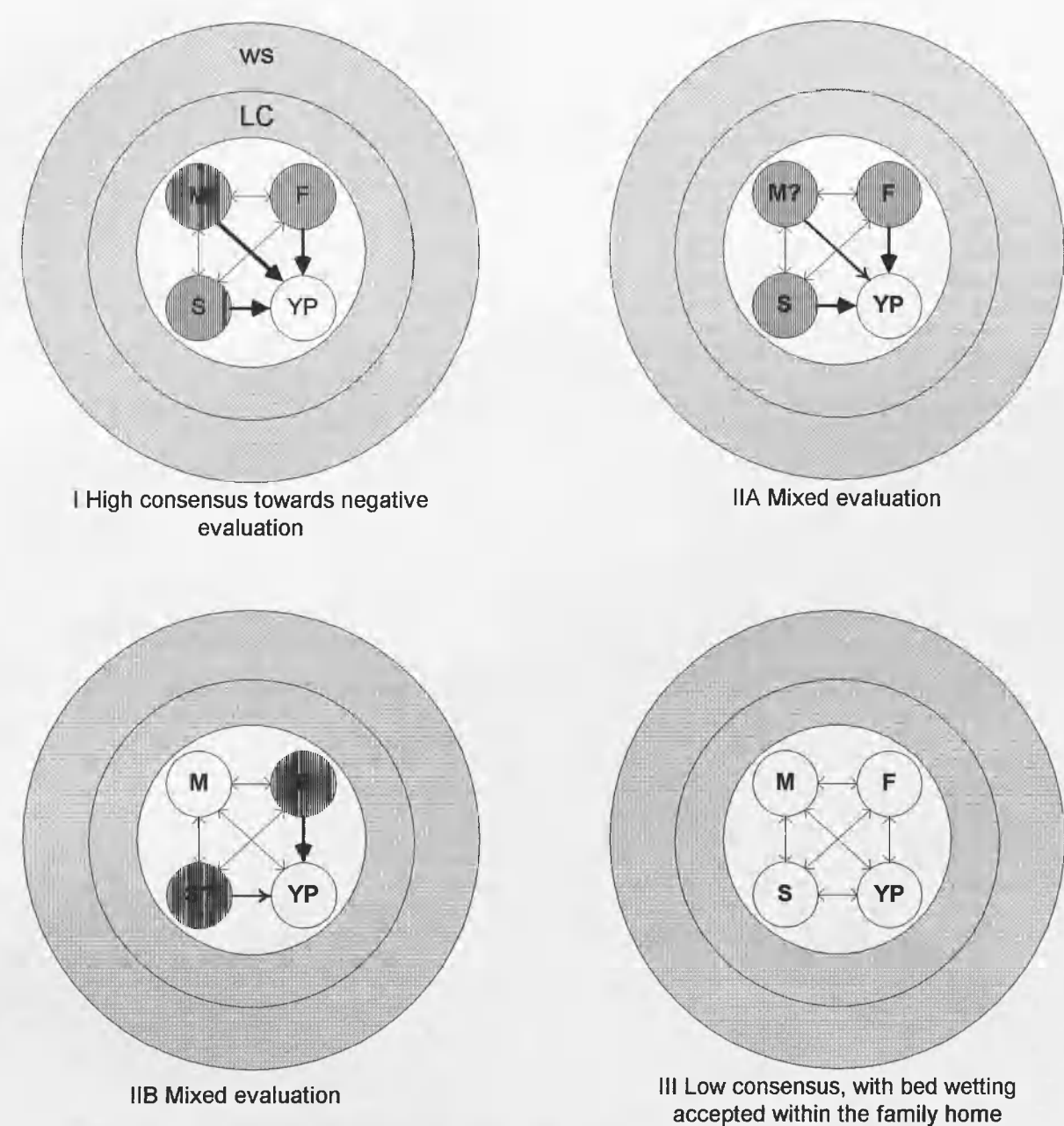
It was noticed that in one family the consensus with which the young person's bed wetting was negatively evaluated was high (Figure 26, pattern 1). Both Sarah's parents were intolerant of the bed wetting (Section 6.3.2) and her father had abdicated all responsibility for helping his daughter and his wife with it. Sarah's older sister was also said to be disapproving:





"MRS S: ... my husband is not the least bit interested in it and her sister (age 16) thinks it's dirty and smelly and doesn't want to know."

Mother of Sarah (age 11) 613/67 p.12

Sarah's grandmother would not let her stay in her house or caravan (Section 5.4.3). Sarah herself seemed to be ambivalent in her attitude to the bed wetting (Section 6.4.2).

FIGURE 26 The consistency with which the young person's bed wetting is negatively evaluated by others, within and outwith the family (see Section 6.5.2)



| KEY (see also Figure 9) | |
|--|---|
| <p><u>OUTWITH THE FAMILY SYSTEM</u> (= SUPRASYSTEM)</p> <p>WS = wider society</p> <p>LC = members of the local community e.g. extended family, friends and neighbours.</p> <p> = regard bed wetting as inappropriate for the young person's age (individuals may or may not be intolerant of the bed wetting)</p> | <p><u>WITHIN THE FAMILY SYSTEM</u> M = mother F = father S = sibling YP = young person who wets the bed Individual member's attitudes to the bed wetting:</p> <p> = rejection and intolerance</p> <p> = ambivalence</p> <p> = acceptance and tolerance</p> |

In two families, the families of Potor (age 15) and Anthony (age 16), the father was intolerant of the bed wetting and the mother was ambivalent about it (Section 6.3.2). Anthony's sister Susan (age 15) disapproved of it as well (Figure 26, pattern IIA). Anthony and Peter seemed to vacillate between optimistic pragmatism and resigned helplessness and hopelessness, but for the most part tended towards the latter perspective.

In Gary's family the father was intolerant of the bed wetting but the mother was not (Figure 26, pattern IIB). Gary (age 5) seemed happy about wetting the bed, for the reasons described in Section 6.4.2. In Michello's family, the mother was more intolerant of the situation than her second husband, who seemed to accept it but he had little practical involvement with it. By the time of the study Michelle (age 8) seemed anxious that the bed wetting should stop but there was evidence to suggest that she may have been happy about it when she was younger (Section 6.4.2).

At the time of the study both the parents in 14 of the 19 families seemed to have adopted an attitude of acceptance and tolerance and there was little evidence that the siblings were consistently disapproving (Figure 26, pattern III). The attitude of the young people in these families varied from resigned or optimistic pragmatic acceptance, to rejection and intolerance or resigned helplessness and hopelessness (Table 17). However, in only three families did it appear that an attitude of optimistic pragmatism had been consistently held by the parents and in each case the young person was optimistic about the future and only minimally concerned about the bed wetting in the mean time. The young people in these families were, nevertheless, aware of the negative evaluation of bed wetting by people outwith the family and two of the three were fearful of the consequences of their bed wetting being discovered by others (Section 5.3.2).

Some of the antecedent conditions giving rise to young people's attitudes are described more fully in Section 6.4.2. Their parents' evaluation of them as a bed wetter appeared to be only a part of the story. Experience of repeated failure to achieve dry nights and predispositional tendencies also appeared to be important determinants of these young people's attitudes.

The consequences of the emotion of shame

Attribution theorists, such as Weiner (1992), suggest that shame results when failure is attributed to lack of ability. Weiner (1992) and Lazarus (1991) suggest that as a consequence of experiencing shame the individual experiences further loss of control, feels powerless and usually withdraws from public contact. As Lazarus (1991, p.244) describes it, the action tendency accompanying shame is:

"... to hide, to avoid having one's personal failure observed by anyone, especially someone who is personally important. To publicly expose one's failure to live up to an ego-ideal is to risk disapproval and quite possibly even rejection".

Young people's feelings of shame about wetting the bed were suggested in so many ways including: their reluctance to tell their parents in the morning that the bed was wet, and hiding wet night-clothes (Section 5.1.2); their humiliation on being put back into nappies (Section 5.1.3); their avoidance of staying away with friends, in some cases (Section 5.3.3); their reluctance to discuss their bed wetting with friends and their reluctance to admit that siblings and friends knew about the problem (Sections 5.3.1 and 5.3.2), and their non-verbal behaviour when discussing the bed wetting with the researcher (Section 3.7.2.2).

In this study children as young as four years of age had learned to feel ashamed of wetting the bed. Only one young person did not seem fully aware that his bed wetting behaviour might be disapproved of by others. In this case the mother had gone to great lengths to protect her son from the disapproval of others.

Many parents commented on the difference in the young person's behaviour on "dry" mornings, when the young person was reported to be much more sociable (Section 5.1.2). One mother also commented upon the difference in her son's behaviour at bed times once he had become dry (Section 5.1.3).

The consequences of the negative emotion of shame for the young person's motivation to be dry is usually motivational inhibition (Weiner, 1992) but if the young person comes to believe that some

control might be possible then shame can lead to a redoubling of efforts, as illustrated by the cases of Simon and Paul in this study (Sections 6.4.2 and 6.6.1).

The consequences of the disapproval of others for the young person's self concept more generally are discussed below.

The effect of bed wetting on self concept

Self concept is defined by Burns (1980, p.171) as:

" ... the set of attitudes a person holds towards himself ..."

Burns suggests that self concept is composed of two elements: self image and self esteem. Self image is a "self-picture", the answer to the question, "who am I?" which contains:

" ... all one's attributes, self conceptualizations, role and status characteristics, possessions and goals."

Burns (1980) p.173

Self esteem is defined by Burns (1980, p.174) as:

" ... the evaluation or judgement placed on each element of the self image."

Self esteem is therefore multi-dimensional. Mussen et al (1990) suggest that although children seem to have a general sense of self worth, self esteem varies for different domains of behaviour.

In the present study most of the young people seemed to have a positive view of themselves in general although they were, for the most part, unhappy about and ashamed of their bed wetting and wanted it to stop (Section 6.4.2). This is congruent with the findings of Butler (1994), Moffatt et al (1987) and Wagner and Geffken (1986) who found that the children in their study had a relatively positive view of themselves, which they assessed using their Child Attitude Scale (CAS).

In the present study no formal instruments were used to measure the young person's self esteem. Measuring self esteem in children is fraught with methodological difficulties. According to Mussen et al (1990, p.391) pre-school children almost always say that they are satisfied and happy with themselves,

"accompanying their comments with a slightly mystified look". Mussen et al (1990) suggest that children have a more clearly formulated sense of self worth and competence by the age of nine or ten but from this age they may not want to admit to others that they have undesirable qualities and they may report more positive self esteem than they really feel.

Many factors are known to affect a young person's feelings of self worth including family disruption and breakdown (Amato, 1986a,b; Burghes, 1994; Cockett and Tripp, 1994; Hetherington, 1989; Mennen and Meadow, 1994), parents' behaviour towards the young person more generally (Baumrind, 1991; Clarke-Stewart, 1988; Gecas and Schwalbe, 1986; Lamborn et al, 1991) and the appraisal of the young person by teachers at school (Graham, 1990) (Section 2.3.1). All that can be said is that negative self evaluation as a result of wetting the bed may contribute to the young person's overall sense of self worth which is derived from many sources. If the young person has developed a negative self image from other sources, negative self evaluation as a result of bed wetting may add to this. If the young person has a more positive self image on the whole, it may be easier for him or her to accept that lack of bladder control is an isolated instance of lack of competence.

6.5.3 The reinforcement of parents' and young people's attitudes as family members interact from day to day

This section is about the way in which the beliefs and attitudes that parents and young people bring to any situation relating to bed wetting (Sections 6.3.2 and 6.4.2) tend to be reinforced as each interprets and responds to the other's behaviour.

Seen from a systems perspective and the naturalist paradigm, which emphasise mutual simultaneous shaping, the concept of linear causality is illogical. The emphasis shifts from seeing parents' actions as the "cause" of outcomes for the child (a psychological approach to the family and child development which dominated family research from the 1950s to the 1970s) to an attempt to understand the influence that family members exert on each other, through their words and actions. Communication is

seen as a jointly constructed activity in which participants mutually evoke verbal and non-verbal messages and modify their own messages in response to the feedback that they receive.

The section begins by describing the origins of the conceptual model (Figure 14, p. 196) which illustrates the relationship between beliefs, feelings and behaviour as a parent and a young person interact from day to day. It is shown that the inferences drawn by young people and their parents as they seek to interpret each others' behaviour tend to reinforce their own personally held beliefs, which may be tenaciously held, even in the presence of conflicting evidence. It is argued that the social and emotional environment created for the young person to learn the skill of becoming dry at night is a reflection of the attitudes that each party brings to it and acts out. It is suggested that the nature of the young person's response also affects the nature of the parent's experience of bed wetting.

The origins of the conceptual model

The conceptual model illustrated as Figure 14 had as its origins a logic diagram drawn by the researcher in an attempt to determine the sequence of events as a young person and his parents interpreted and responded to each other's behaviour on a "wet" morning (Figure 27).

This figure is based on an analysis of a single case, the case of Peter (age 15) and his parents. The logic diagram begins with a brief note of some recurring themes which had emerged during data analysis more generally, before summarising an "event" described more fully by Peter's father:

"MR P: ... he gets up in the morning and he is - he has a shower. He spends maybe 20 minutes in the shower as if he wants to purify himself and get rid of everything a million per cent, so he walks out as a clean person and just leaves the bed behind for somebody else to deal with.

MOYA: And how do you feel about that?

MR P: I don't know - I think to a certain extent it's a psychological problem with Peter - that he just seems to shut off - he doesn't want to face up to the problem."

Father of Peter (age 15) 15124/4 p.2

This story has many features in common with other parents' descriptions of their children's behaviour on "wet" mornings (Section 5.1.2).

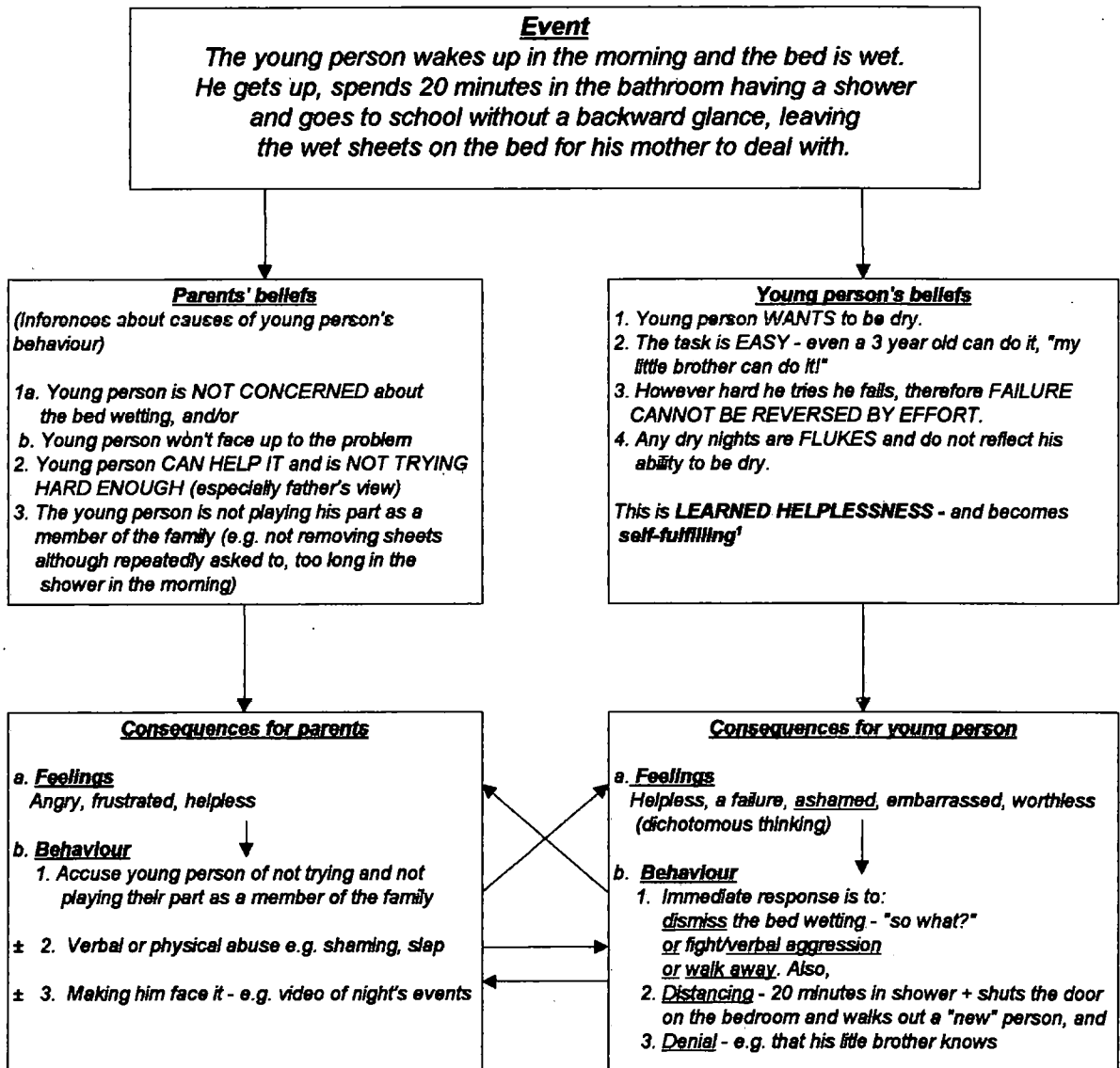
FIGURE 27 An example of a logic diagram:

What is going on?

Background: - recurring themes:

- **HELPLESSNESS** - from parents, young people and health care professionals
- many parents **QUESTION** young person's **MOTIVATION** to be dry
- there are hints in the data that most young people desperately **WANT** to be dry e.g. the way their behaviour changes when they are dry

Scenario



Notes

¹ Many parents say of new treatments: "**Everything works for a little while**". This suggests that the young person never totally gives up hope, but **gives up easily** when it looks as though the treatment is failing.

Implications for practice

- a. **Change parents' beliefs** e.g. that young person can help it.
- b. Families can be helped to **cope** with the situation although a cure cannot yet be guaranteed. Coping is facilitated if parents can **accept** the situation.
- c. **Behavioural training** - **reward the truthful keeping of a record** of wet and dry nights, **not** the dry nights themselves, in the first instance.

The inferences that Peter's parents had drawn from their son's behaviour were that he was not concerned about the bed wetting or was not prepared to face up to it, he was not making sufficient effort to help himself and he was not playing his part as a member of the family (Figure 27). At times, his parents felt angry, frustrated and helpless. On one occasion Peter's father videoed his stepson's response to being woken up in the night, to let him see what he was like, to which Peter was said to have replied:

"MR P: (quoting Peter)... 'I wet the bed - I believe you, you've proved your point!'"

Father of Peter (age 15) 1522114/28 p.6

Peter's father had hoped that making his son face the problem would shock him into doing something about it. It was not, however, said to have made any difference to Peter's behaviour. There was no evidence that Peter's parents had used physical punishment although they had come to believe that the bed wetting was to some extent within his control.

Peter's beliefs are also summarised in Figure 27. Peter wanted to be dry but through repeated failure, with every treatment tried (Sections 5.5 and 5.6) he had come to believe that the outcome was not contingent on his efforts and he had given up trying. He kept his diary for the study half heartedly and was said by his mother to have filled in three to four days at a time, when she prompted him. He was clearly ashamed that he could not perform an "easy" task, which even his two and a half year old brother had achieved. He denied that his younger brother knew about the bed wetting (Section 5.3.1) and he distanced himself from the situation, walking away from the wet bed, taking particular care with his personal hygiene before leaving the house "as a clean person".

Peter's parents interpreted his behaviour as lack of effort and refusal to face up to a problem which they had come to believe was psychological, because all physical causes had been eliminated by health care professionals. As described in Section 6.3.2, the parents of Anthony (age 16) had come to similar conclusions, based on similar evidence, which included the young person's half-heartedness when engaging in treatment.

The above example illustrates the potency of certain beliefs as determinants of action, or inaction, and how easy it is for parents to draw inferences from their child's behaviour which reflect only a partial understanding of the situation. Peter had come to an attitude of resigned helplessness and hopelessness (Section 6.4.2) which his parents had interpreted as lack of motivation. Their attempts to encourage him to take more responsibility and to play a more active part in helping himself had failed. The challenge for health care professionals of helping young people and their parents to find some control in a situation where a successful outcome to treatment cannot be guaranteed is discussed in Chapter 7.

Reflecting upon the way in which the beliefs of the members of Peter's family seemed to be influencing their behaviour towards one another led to the development of the classifications of parents' and young people's attitudes to bed wetting (Sections 6.3.2 and 6.4.2) based on a relatively small number of beliefs, including beliefs about perceived control.

In those families where punishment was consistently used it is suggested that the parents' obvious disapproval contributed to the young person's feelings of shame and sense of powerlessness, thereby having the opposite effect to the effect intended, pushing the bed wetting up the family's agenda (Section 5.4.1) and increasing tension between family members at key times of communal family activity (Section 5.1.2). Tracy's mother described what happened on the mornings when she found her daughter's bed was wet:

"MRS T: I just shout at her - I do shout. I say 'Wet again!' you ken. She just marches out the room."

Mother of Tracy (age 9) 1521228/39 p.6

Blaming parents who punish their children for wetting the bed moves an understanding of family process little further forward. By focusing only on parents' responses to a situation the conditions which lead to their behaviour can be all too easily ignored. As is illustrated in this section, parents' misunderstanding of their children's responses to criticism can lead to a self perpetuating cycle in which negative behaviours are continually evoked between and among family members.

In those families where the parents said that they had adopted an attitude of acceptance and tolerance this may have helped to ease the young person's feelings of shame and helped to create a more supportive social environment for the young person to learn the skill of becoming dry at night.

However, there was evidence that parents and young people sometimes saw situations differently:

"MR C: I don't bother about it. It's an illness you can't help, you can't do anything about. So you've got to take it or leave it - like it or lump it - just take it as it comes. You've got to take it - the things I've seen! - this is nothing. So what?

CAROL: That's not what you say to me! You give me big lectures about it!

MR C: Yes, so what? It doesn't bother me, like. I just give you lectures because you lie in it ... she just lies in it and doesn't tell anybody. That's what gets me about it."

Stepfather of Carol (age 17) 121111/64 p.5

Carol had adopted an attitude of resigned helplessness and hopelessness (Section 6.4.2). Carol's apathy in the mornings was interpreted by her stepfather as a lack of willingness to help herself in ways that she could control and she described the worst thing about bed wetting as:

"CAROL: ... getting shouted at, having to get up for a bath and changing my bed, then getting slagged off."

Carol (age 17) 3214/29 p. 2

Even in those families where the parents seemed to have adopted an optimistic attitude towards the bed wetting, many young people had a pessimistic view of their parents' evaluation of their behaviour. It may take no more than an occasional disapproving glance at a wet bed by a parent to reinforce the young person's belief that their bed wetting is unacceptable behaviour.

In conclusion, while the interactions between family members appeared to the researcher, as "on-looker", to be reflexive, individuals within the family seemed to be seeing and interpreting situations in a linear fashion and from their own perspective, as illustrated above. As a consequence of this way of thinking parents seemed to perceive their own behaviour primarily as a response to the behaviour of the bed wetting child. For the most part they seemed to be quite unaware of the existence and consequences of mutual influence and their own contribution to the situations in which they found themselves.

6.6 Perceived helplessness and perceived control

6.6.0 Introduction

Perceived helplessness appeared in many guises in the data and was at first identified as the central phenomenon or core concept in this study. Further analysis suggested that this concept was transcended by the concept of perceived control (Section 6.2.1). The phenomenon of perceived helplessness, its antecedent conditions and its consequences, are explored in Section 6.6.1. A concept analysis of perceived control is given in Section 6.6.2 where this study's findings are briefly compared with the vast body of research into this construct which has been conducted in other settings.

6.6.1 Perceived helplessness

The causal conditions for perceived helplessness and feelings of shame experienced by young people in this study were identified as:

- **past experience of repeated failure with treatment**
- **unrewarded effort**
- **the belief that most three year olds are able to be dry at night, which defines the task as easy, and**
- **negative evaluation of bed wetting by others.**

Burns (1980) suggests that individuals behave according to their self conceptualisation, so that it becomes a self-fulfilling prophecy. The self image is validated by behaviour which in turn generates confirmatory feedback from others. A major consequence of feelings of shame and belief in helplessness is that many young people come to behave as though they are helpless. They may refuse to participate in treatment regimens suggested by others or at best their participation is half-hearted (Section 5.6.1). They do not sustain their efforts to become dry for long enough for the method to achieve the desired outcome. They are easily discouraged and interpret setbacks as confirmation that any initial success was due to chance, and their belief in their inability to influence the situation is reinforced. Furthermore their apathy is often construed by their parents as a lack of concern about

the bed wetting (Section 6.5.3) and they may be punished for not making sufficient effort to help themselves (Section 5.5.3). The result can be a cycle of helplessness involving both parents and young people. The situation is summarised in the axial coding diagram illustrated in Figure 28.

Establishing the sequence of events depicted in Figure 28 helped to account for many young people's attitudes towards bed wetting of resigned helplessness and hopelessness (Section 6.4.2) which was characterised by both apathy and sadness.

Lazarus (1991) describes sadness as a negative emotion which is usually linked to loss, such as the death of a loved one, the failure of a central life value or role, or the loss of the positive regard of another person whose opinion is valued. He suggests that sadness is characterised by:

- irrevocable loss
- a sense of helplessness about restoration of the loss, and
- resignation rather than struggle.

Sadness, he suggests, indicates a move towards acceptance of and disengagement from the lost commitment. He suggests that emotional distress is actually attenuated when the individual "gives up" something that is perceived to be irrecoverable. In this sense giving up may serve an adaptive function. Futile endeavour is maladaptive.

Lazarus (1991) suggests that if the person does not perceive himself or herself to be completely helpless then other emotions are more likely in response to loss, such as anger, guilt or hope, which are associated with the initiation of restorative actions. While sadness is characterised by low engagement, as was seen in those young people who had adopted an attitude of resigned helplessness and hopelessness (Section 6.4.2) the emotions of anger, guilt or hope are accompanied by higher engagement in activities aimed at restoring what has been lost, in this case both bladder control and the self esteem associated with it.

FIGURE 28 The use of a coding paradigm (axial coding) to explore the phenomenon of perceived helplessness, as experienced by many young people who wet the bed

**A. CAUSAL
CONDITIONS**

1. Past experience of repeated failure with treatment methods, whether or not prescribed by health care professionals
2. Unrewarded effort
3. The belief that most 3 year olds are dry at night
4. Negative evaluation of bed wetting by others

B. PHENOMENON

Perceived helplessness and feelings of shame

Young people who wet the bed come to believe that they cannot achieve their desired goal of becoming dry at night through their own efforts and that any dry nights that they do experience are due to chance. They feel ashamed at their lack of ability to do what a younger child can do. (Sections 6.4.2 and 6.6.1)

C. CONTEXT

1. Past experience of repeated failure

(Sections 5.5 and 5.6 - the young person may have engaged in many methods in the past to attain night time continence and none of them has led to the achievement of the desired outcome)

2. Unrewarded effort

(Sections 5.5 and 5.6 - the young person wants to be dry at night but has achieved no more than the occasional dry night however hard he has tried in the past)

3. The knowledge that most 3-year olds are dry at night

(Section 5.3.1 - a younger brother or sister may now be dry)

4. Negative evaluation of the bed wetting by others

(Sections 5.3 and 5.4 - the young person receives the message that he ought to be able to be dry at night from others within and outwith the household. [Relates to bed wetting being, in part, a social construct (Section 2.2.1).] The consistency with which the young person receives the negative meta message that his behaviour is both unacceptable and within his control contributes to the young person's feelings of shame and helplessness.)

**D. INTERVENING
CONDITIONS**

1. Parents may believe themselves to be helpless, feel helpless and behave as though they are helpless, from time to time

(Sections 6.3.2 and 6.5.1)

2. Health care professionals may believe themselves to be helpless, feel helpless and behave as though they are helpless, from time to time

(Section 5.6 - based on their past experience of repeated failure and unrewarded effort)

E. ACTION/
INTERACTION
STRATEGIES

Young people come to behave as though they are helpless

1. Young people then do not sustain their efforts to become dry at night for long enough for the method to achieve the desired outcome because they do not expect it to be successful (*Sections 5.5 and 5.6*)
2. They are easily discouraged and interpret setbacks in treatment efficacy as confirmation that any initial success was due to chance. Their belief in their own inability to influence the situation is reinforced by failure
3. They may refuse altogether to participate in treatment regimens suggested by others or at best participate half-heartedly

F. CONSEQUENCES

How parents and young people interpret and respond to each other's behaviour on "wet" mornings (*Section 6.5.3*)

1. Parents interpret the young person's behaviour as proof that:
 - a. the young person is not concerned about wetting the bed, or won't face up to the problem
 - b. the young person is not playing his part in helping the bed wetting to stop
2. The parents feel angry, frustrated and perhaps helpless
3. On finding that the young person has wet the bed the parents may:
 - a. express their feelings of anger and frustration, verbally as well as non-verbally
 - b. accuse the young person of not making the effort to be dry
4. The young people feel helpless and ashamed and may:
 - a. reflect the parents' behaviour back to them on 'wet' mornings, or walk away from a confrontation
 - b. distance themselves from the bed wetting by taking special care with their hygiene before leaving the house (*perhaps an end stage phenomenon is when they don't do this but actually lie awake in a wet bed, this could be the ultimate signal that the young person really has given up trying*)
5. The cycle of helplessness for both parents and the young people who wet the bed is self-perpetuating.

7/4/95

Those young people who had adopted an attitude of optimistic pragmatism towards their bed wetting (Section 6.4.2) felt helpless to influence the situation at that time but they were not without hope that they would one day be dry. In more than half of these cases their parents had been bed wetters and had become spontaneously dry so these young people knew from experience close to home that dry nights were possible. The message of Ian's parents to their son was characterised by hope for the future:

"Mr I: We keep hoping that this is the time.

MRS I: We've told him that.

MR I: Ken, when he reaches a certain age, it's going to stop."

Father and mother of Ian (age 13) 1211/8 p.12

Ian's mother had wet the bed herself until she was 11 or 12 years old.

It so happened that the two young people who were most angry about their bed wetting, Simon and Paul (Section 6.4.2) had also taken the most responsibility for helping themselves to be dry and actually became dry shortly after their enrolment into the study. It is suggested that this attitude towards the bed wetting may have contributed to the outcome.

Ford (1992, p.137) describes anger as an energising emotion:

"... anger and determination ... may be just what is needed to overcome seemingly intractable obstacles to goal attainment ... 'I'm mad as hell, and I'm not going to take it any more!'"

Lazarus (1991, p.218) suggests that blame rather than mere accountability is crucial for anger:

"To blame persons, rather than simply hold them accountable or responsible ... requires ... that we believe that they could have acted differently, that they had control over the offending action."

While anger is usually directed towards others it can be directed inwards, as is believed to have been the case for Simon and Paul, with the result that they redoubled their efforts to be dry. The fact that they were angry rather than sad about their bed wetting suggests that they had come to believe that they could exercise some control over the situation, that they could act differently. Paul's father

described how his son's attitude towards his bed wetting changed from sadness to annoyance, which led to action:

"MR P: ... its stymied him as far as going off and doing things - for a while - then he thought, 'nuts to it!' - you know - carried on - which is a great credit to him ... once he took control of himself - and you know, was saying 'I'm so frustrated by this, I must do something about it' and when he got to that stage it started to change. Because he was then feeling as though he was in control of himself and making his own decisions, and making his own mind up about it."

Father of Paul (age 13) 113/3 and 4 p.1-2.

6.6.2 Perceived control

"In the broadest sense, perceptions of control can be thought of as naive causal models individuals hold about how the world works: about the likely causes of desired and undesired events, about their own role in successes and failures, about the responsiveness of other people. ... People strive to experience control because humans have an innate need to be effective in interactions with the environment."

Skinner (1995) p.xvi-xvii

Five decades of research have established perceived control to be powerfully predictive of people's behaviour and motivation in many domains of life including: adaptation to chronic illness (Affleck et al, 1987; Braden, 1992; Hewlett, 1994; Watson et al, 1990); pain management (Arntz and Schmidt, 1989; Clements and Cummings, 1991; Walding, 1991); patient decision making (Fuchs, 1987; Kaplan, 1991); adjustment to ageing (Brandstaedter and Renner, 1990; Foy and Mitchell, 1990; Reich and Zautra, 1991); academic performance in school children (Patrick et al, 1993; Schmitz and Skinner, 1993; Skinner et al, 1988a,b), and coping with stress (Compas et al, 1991; Wannon, 1990).

This brief review of the concept of perceived control begins with an overview of four distinct yet interrelated constructs which have contributed to an understanding of a system of beliefs which transcends it, which is sometimes referred to as the competence system (Connell and Wellborn, 1991; Skinner, 1995). The four constructs are:

- locus of control (Rotter, 1966, 1975; Lefcourt, 1992)
- learned helplessness (Seligman, 1975; Abramson et al, 1978)
- causal attribution (Weiner, 1986, 1992), and
- self-efficacy (Bandura, 1989).

There are many other related concepts, such as Ford's (1992) concept of personal agency beliefs which are incorporated into other theories of motivation. This brief review has been restricted to the concepts listed above because they have formed the basis of a great deal of research into the related constructs of perceived control, motivation and coping.

Locus of control

In the original formulation of this theory Rotter (1966, p.1) describes two perspectives that individuals may have of their control over the outcomes of their actions:

"When a reinforcement is perceived by the subject as ... not being entirely contingent upon his action, then ... it is typically perceived as the result of luck, chance, fate, as under the control of powerful others, or as unpredictable ... When the event is interpreted in this way by an individual, we have labelled this as a belief in *external control*. If the person perceives that the event is contingent upon his own behaviour or his own relatively permanent characteristics, we have termed this a belief in *internal control*."

Locus of control is said to influence success or failure through its effects on effort expenditure and persistence in the attainment of a goal. It was proposed that locus of control influences the individual's expectancy of success in any situation. An internal locus of control has been said to predict a more positive outcome than an external locus of control in a variety of situations (Strickland, 1989; Lefcourt, 1992). Hundreds of studies have involved the measurement of locus of control but Ford (1992) suggests that this literature is filled with results that are anomalous or hard to interpret. He warns of the dangers of assuming that predictive precision is achievable using such a global measure of the perceived control construct as no account is taken of the influence of context.

In a critique of locus of control as a construct Skinner (1995, p 4) comments:

"... it is easy to assume that an individual's generalized sense of control constitutes a stable, enduring, cross-situational trait-like predisposition ... Studies in which individuals are labelled as 'internals' and 'externals' contribute to this impression. In current conceptualizations, however, perceived control is usually considered a flexible set of inter-related beliefs that are organized around interpretations of prior interactions in specific domains."

Skinner suggests that an individual's perceived control is not a fixed and enduring personal quality but involves a set of personally constructed beliefs which can be changed in the light of new experience, even if a great deal of contradictory evidence is required to alter them.

Locus of control was not measured in the participants in this study but a clear impression was gained from talking with both young people and their parents that the young people's perceived lack of control over their bladder function at night was regarded by most as a very situation-specific phenomenon. There was, however, a small group of young people, such as Carol and Stephen, who behaved as though their predominant tendency was towards a belief in external control and the attitude of these young people to their bed wetting was one of resigned helplessness and hopelessness (Section 6.4.2).

Learned helplessness

The theory of learned helplessness has undergone several revisions since it was originally proposed in the early 1970s. The original studies examined the links between non-contingency and subsequent cognitive, behavioural and motivational deficits. Based on the findings of experiments involving rats and dogs (Richter, 1958; Seligman and Maier, 1967) the central proposition was that when people experience aversive events that occur independently of their own responses they learn that they are helpless and this belief in helplessness becomes more generalised. When people who have learned that they are helpless in one situation are placed in situations where some control is possible, it is suggested that they continue to behave as though they are helpless, that is they are passive and do not seek out the control that is possible.

Learned helplessness has been implicated in some forms of depression (Abramson et al, 1989; Hiroto and Seligman, 1975; Seligman, 1975; Wetzel, 1994) and has been reported as an outcome for both women and children following years of physical or sexual abuse (Blair, 1986; Kelley, 1986).

Since its original inception the theory has been revised. According to Abramson et al (1978) following experiences of non-contingency individuals seek to explain the cause. The attribution for response-outcome non contingency can be classified on three dimensions of causality: locus,

stability and globality. Stability leads to chronicity, globality is a measure of cross-situational generality and locus affects the individual's self esteem.

It is not known whether young people's experience of helplessness with respect to their lack of control over their bed wetting, which in some cases had been experienced for many years, had affected their perception of their own control in other situations or whether and to what extent it may have contributed to more general feelings of resigned helplessness and hopelessness where these were in evidence.

Causal attributions

Weiner (1986, 1992) has developed a theory of motivation based on causal attribution. He proposes that when something negative or unexpected happens people ask themselves why. The causes to which individuals attribute events can be placed along a number of dimensions which include: internality, stability, controllability and intentionality. These dimensions predict many important outcomes such as emotions, behaviour and the motivation to act.

When an individual attributes a successful outcome to their own ability, it leads to enhanced self esteem, high expectations of success in the future and persistence with the activity in the mean time. When an individual attributes lack of success to low ability, as a result of persistent failure in the past, in spite of effort, the individual experiences low self esteem, feels helpless, expects failure in the future and is unlikely to persist with the activity. This is reminiscent of the behaviour of many young people in this study who believed themselves to be helpless to stop their bed wetting (Section 6.6.1).

Weiner's attribution theory has found applications in many domains ranging from scholastic achievement and achievement in the work place to recovery from: rape; life-threatening illness, and traumatic accidents (Skinner, 1995). Causal attributions can influence motivation in powerful ways by altering an individual's expectations in relation to capability of achievement in the future.

Self efficacy

According to Bandura (1989) an individual's emotions and behaviour are a reflection of the interaction of self efficacy and outcome expectancy. Effective action is most likely when an individual has a positive judgement of his self efficacy and a high expectation of a positive outcome. An individual who believes that his self efficacy is low and a positive outcome is unlikely is, by contrast, likely to be apathetic and resigned. If a person with a belief in his own low self-efficacy believes that others do enjoy the benefits of their efforts then Bandura suggests that the result is self devaluation and despondency. This is akin to the situation for many bed wetters who believe that they themselves have no control over the situation which can be controlled by most 3-year olds. They believe that the task is easy and should be readily achievable because most pre-school infants can achieve it. Bandura (1989) suggests that an individual's expectation of success in a given situation may be enough to create that success and even to blunt the impact of minor failures. The illusion of control may be adaptive if it leads to positive emotions such as optimism. This theme is explored further in Chapter 7.

A new conceptualisation of perceived control

Based on research into perceived control and achievement in school children (e.g. Skinner et al, 1988a,b; Schmitz and Skinner, 1993) and drawing upon different aspects of perceived control highlighted by studies of the related constructs of locus of control, learned helplessness, causal attribution and self efficacy described above, Skinner (1995) has proposed a new conceptualisation of perceived control.

She distinguishes between three kinds of belief:

- **control beliefs** - which refer to generalised expectancies about the extent to which the self can produce desired or prevent undesired events
- **strategy (means-end) beliefs** - which refer to generalised expectancies about the extent to which certain means are sufficient conditions for the production of ends (outcomes), and
- **capacity (agency) beliefs** - which refer to generalised expectancies about the extent to which the self possesses or has access to certain means.

Skinner proposes that these three belief sets function in the regulation and interpretation of action. Strategy and capacity beliefs are involved in the evaluation and interpretation of performance. They are both used in the individual's attempt to understand the meaning of successes and failures and are themselves influenced by performance outcome. Control beliefs are a combination of strategy and capacity beliefs. Control beliefs are analogous to performance expectations and success estimation. According to Skinner's (1995, p.35-36) conceptualisation, strategy and capacity beliefs are independent:

"A person can be high on capacity ('I have all the means') and still report low strategy beliefs ('But none of the means produce any outcomes'). Or a person can be high on strategy beliefs ('There are lots of means that lead to outcomes') but still perceive him - or herself - as lacking in capacity ('But I don't have any of them')."

Strategy beliefs are about "what it takes to ..." while capacity beliefs relate to the individual's perception of himself as "having what it takes to ...". Strategy beliefs have a parallel in the construct of locus of control and include beliefs about whether the outcome is dependent upon: effort, ability, powerful others or luck. Skinner et al (1988a,b) used these dimensions to develop profiles of perceived control which they postulated would predict engagement versus disaffection in the academic domain.

Skinner et al (1990) found that children's engagement was positively related to control beliefs and capacity beliefs for effort and ability, in the way predicted and was undermined by strategy beliefs relating to luck. The highest levels of engagement were found among children who reported that effort was an effective means and that they had the capacity to exert effort.

It is suggested in Chapter 7 that similar research into young people's control beliefs could be helpful in predicting which young people are likely to persist with treatment for their bed wetting for long enough for it to be effective. It is suggested, however, that prolonged engagement is also likely to be strongly influenced by parents' own control beliefs as most young people are likely to require a measure of help and support during this time (Chapter 7).

In seeking an answer to the question: "How do individual differences in perceived control develop?" Skinner (1995) puts forward a theory based on the assumption articulated by Seligman in 1975 in

relation to learned helplessness, namely that control beliefs and their consequences can create a self-perpetuating cycle:

"Individuals who believe they have control act in ways that make success more likely and so confirm their initial high expectations of control. Furthermore, their sustained engagement in challenging tasks is likely to lead to the development of actual competence over time. In contrast, individuals who do not believe they can influence outcomes act in ways that forfeit opportunities for exerting control. Over time, through their passivity and avoidance of difficult tasks, they forego the development of new competencies. Individual differences in developmental trajectories of both subjective control and objective competence will result."

Skinner (1995) p.xvii

The challenge for health care professionals is to foster in young people who wet the bed, and their parents, a belief that some control over the situation is possible (Chapter 7).

6.7 Summary

Most young people are sad and ashamed about wetting the bed and want it to stop but they vary widely in their belief in their own capacity to influence the situation and in their optimism about what the future holds.

Young people learn to feel ashamed of their bed wetting because of the negative evaluation of this behaviour by others, both within and outwith the household. They define the task as "easy" because they believe that most three year olds can achieve it. As a result of past experience of repeated failure to become dry at night, however hard they have tried, they attribute their own lack of success in this task to lack of ability. The threat posed to their self esteem by the censure of others causes many young people to try to hide their "deficiency" from others and to avoid situations which might lead to the discovery of their secret.

When a young person is blamed for wetting the bed the young person's feelings of humiliation and shame are reinforced because they have failed to live up to an ego-ideal and have disappointed another person or other persons whose approbation matters to them. As a result the young person experiences a further loss of control, an increasing sense of powerlessness and motivational

inhibition. This is often interpreted by parents as a lack of concern. The young person is blamed for lack of effort and the cycle can become self perpetuating.

In situations where the young person is blamed and the bed wetting moves up the family's agenda, tension relating to bed wetting may increase as the young person's belief in his capacity to influence the situation declines, making the attainment of the desired goal less likely. The widespread practice by parents and others of blaming young people who wet the bed is therefore counter productive.

The implications of this study's findings for practice are explored in Chapter 7. This includes a discussion of how young people, their parents and indeed health care professionals can increase their belief in their capacity to influence a situation where the treatment process for bed wetting is controllable but where a rapid and successful outcome cannot be guaranteed.

CHAPTER 7: IMPLICATIONS FOR PRACTICE AND POSSIBLE DIRECTIONS FOR FURTHER RESEARCH

7.0 Introduction

The findings of this study have a number of implications for practice, many of which could form the basis for further research.

The aetiology of bed wetting and how best to treat it are still matters of considerable debate (Chapter 2). As suggested by the data presented in Chapter 4 and elsewhere, understanding more about the natural history of the acquisition of nocturnal bladder control could be a fruitful line of inquiry. The focus of this study and this chapter is, however, on the family as the context within which bed wetting is experienced and treated. The chapter begins by outlining the conditions suggested by the data to be required to maximise the likelihood of a successful treatment outcome (Section 7.1). The concept of a family's readiness to engage in treatment is explored in Section 7.2. Some ways of enhancing young people's, parents' and health care professionals' sense of competence, in a situation where many individuals have come to believe themselves to be helpless, are described in Section 7.3. Many professionals can become involved in helping families where one or more young person wets the bed. The implications of this study for service organisation are given in Section 7.4.

7.1 Some conditions required to maximise the likelihood of a successful outcome to treatment

It is strongly suggested by the data that the following conditions (C1-C5) may need to be met for the young person to have the best chance of achieving dry nights as the result of an intervention:

$$C1 + C2 + C3 + C4 + C5$$

- C1 = both the young person and the parents want the bed wetting to stop**
- C2 = both the young person and the parents believe that the achievement of dry nights is contingent upon their efforts and that they are capable of making the effort required**
- C3 = the goal of achieving dry nights is not out-competed by more pressing priorities on the family's agenda for action**

- C4 = the family gain access to a treatment method appropriate to the young person's needs, which is within both the parents' and the young person's capability
- C5 = the family have easy and rapid access to professional support and help especially if they experience equipment failure, apparent lack of progress or the young person or the parents cease to believe in treatment.

It is suggested that in the absence of any one of these conditions it is unlikely that any treatment prescribed by health care professionals will be sustained for long enough to stand a good chance of success.

These conditions were arrived at empirically but they have been found to be congruent with Ford's (1992, p.69) scheme for classifying the processes which contribute to goal achievement:

$$\text{Achievement/Competence} = \frac{\text{Motivation} \times \text{Skill}}{\text{Biology}} \times \text{Responsive Environment}$$

Ford (1992) suggests that achievement is the result of a motivated, skilful and biologically capable person interacting with a responsive environment, which facilitates, or at least does not excessively impede progress towards a goal. However Ford (1992, p.124) suggests that it is not enough to have a goal in mind and the objective skills and circumstances to achieve it:

"People must also *believe* that they have the capabilities and opportunities needed to achieve their goal. Indeed, such beliefs are often more fundamental than the actual skills and circumstances they represent in the sense that they can motivate people to create opportunities and acquire capabilities they do not yet possess ...[quoting Kolligan and Sternberg, 1990]: 'At all points in the life cycle it is one's construal of reality, rather than reality itself, that most accurately predicts self-concepts, goals, academic performance, and overall mental health'."

It is suggested in the conditions (C1-C5) listed above, that capability beliefs are necessary for a successful outcome to an intervention but they are not sufficient to ensure a successful outcome. As well as not being out-competed (C3), it is suggested that the families require to be provided with a responsive and supportive environment by health care professionals.

In the present study the parents clearly felt that most health care professionals had little to offer them, although their intention to be facilitative was rarely questioned (Section 5.6). This situation is not helped by the lack of certainty amongst professionals about the aetiology of bed wetting (Section 2.2.1) and how best to treat it (Section 2.2.3). The need to enhance health care professionals' sense of competence in the context of the management of bed wetting is touched upon in Section 7.3.

7.2 Assessing the family's readiness to engage in treatment

The data from this study suggest that most parents believe that they are helpless, feel helpless, and behave as though they are helpless to influence the young person's bed wetting from time to time. In some cases this belief is accompanied by feelings of hopelessness (Section 6.3). It has also been shown that many young people come to believe that they are helpless, feel helpless and behave as though they are helpless to stop wetting the bed (Section 6.4). A relationship between the parent's and the young person's perception of themselves as helpless to influence the situation and the likelihood of the family taking and persisting with action to encourage the bed wetting to stop is proposed in the form of a conditional matrix (Figure 29).

It is suggested that the testing of the hypotheses depicted in Figure 29 could be a fruitful line for research. The two components of perceived control, namely strategy beliefs and capacity beliefs, proposed by Skinner et al (1988a,b) (Section 6.6.2), could be tested using a form of the Perceptions of Control Questionnaire (Skinner, 1995), modified for the domain of bed wetting.

If it is confirmed by such research that the combination of the parents' and the young person's perception of control is predictive of their engagement in treatment, and their persistence or otherwise with it in the light of setbacks, it would seem prudent to assess these parameters prior to prescribing any treatment regimen. If either the young person or the parents, or both, are assessed as perceiving themselves to be helpless, it is suggested that the first priority should be to attempt to enhance these individuals' beliefs in their own competence. Some strategies for enhancing the individual's belief in competence are proposed in Section 7.3.

FIGURE 29 The hypothesised relationship between the parent's and the young person's belief in helplessness and the likelihood of action being taken to encourage the bed wetting to stop, once the bed wetting has been identified by them both as a problem

| | | Young person, who wets the bed, believes that he or she is HELPLESS | |
|--|-----|--|--|
| | | YES | NO |
| Parent believes that he or she is HELPLESS | YES | <p><u>NO ACTION</u></p> <p>No action taken by parent or young person to stop the bed wetting</p> | <p><u>ACTION UNLIKELY</u></p> <p>While young person may believe that taking action could lead to more dry nights, action is unlikely as parents are the gatekeepers to resources needed to take action</p> |
| | NO | <p><u>ACTION MAY BE INITIATED BUT IS UNLIKELY TO BE SUSTAINED</u></p> <p>Parents may attempt to initiate a treatment regimen but young person's co-operation and commitment is at best half-hearted as their expectancy of success is low</p> | <p><u>BEST CHANCE THAT ACTION WILL BE BOTH INITIATED AND SUSTAINED</u></p> <p>Parent(s) and young person actively engage together in methods to stop the bed wetting - <u>UNLESS</u> the resolution of the young person's bed wetting is out-competed on the family's agenda by more pressing priorities within the family at the time</p> |

It also shown in this study that the active treatment of the young person's bed wetting can be out-competed by other priorities on the family's agenda for action (Section 5.4). Assessing the appropriateness of the timing of any intervention, with families, in relation to other family priorities at the time could be of particular importance in ensuring that the optimum time is chosen to embark on any treatment regimen which is likely to require the prolonged co-operation of all the family.

For treatment to be successful it is axiomatic that the young person should desire the goal which is to be striven for. There is evidence presented in this study to suggest that a small minority of young people may gain some secondary benefits from bed wetting (Section 6.4). This may be associated with a poor relationship with one or both parents. Careful questioning of the young person on his own and of the parents may help to identify such cases, which may not be obvious to a health care professional who does not know the family well.

It may be that the family dynamics are assessed as being so uncondusive to the provision of a supportive environment for the young person to learn the skills of becoming dry at night that the first step in treatment may need to be some form of family therapy to improve communication and to foster positive mutual regard and empathy between family members, as well as to enhance the family's collective problem solving skills.

7.3 Enhancing a belief in competence among young people, their parents and health care professionals

"Tasks of 'just manageable difficulty', which are replete with unsuccessful attempts, are the natural playground for the operation of the competence system, and dealing with them provides learning as well as joy and satisfaction. However, prolonged unpredictability and uncontrollability overwhelm the competence system and, when crystallized as a general sense of incompetence or non-contingency, prevent it from functioning optimally in response to challenges."

Skinner (1995) p.136

The need for competence is considered by Skinner to be an innate and universal human need.

Competence in this context refers to the contingency between behaviours and outcomes and is the

extent to which a person feels capable of producing desired and preventing undesired events. Its opposite is non-competence, that is helplessness (Section 6.6).

Many examples of young people and their parents perceiving themselves to be helpless to influence the bed wetting are given in this thesis. A belief in competence can be enhanced among young people and their parents when they are provided with opportunities for exercising and experiencing effective control.

Exhortations to make more effort may be counter-productive

In situations where individuals already perceive themselves to be doing badly, emphasising the effectiveness of effort may lead them to feel even more incompetent. They may further doubt their own abilities, stop trying and experience increased negative self evaluation. It is suggested that this is what is happening in the cases of those young people who are being told by their parents (usually their fathers) that they could be dry if only they tried harder (Sections 6.3.2 and 6.5.3).

In the academic domain this phenomenon has been described by Covington and Omelich (1979, p.169) as "the double edged sword" of effort. Failure in spite of high effort expenditure is attributed to low ability. Covington and Omelich (1985) suggest in the school setting that given a choice between being judged lazy and being judged stupid, most people prefer to be seen as lazy. It may be that young people who wet the bed would rather be judged lazy than incapable of performing a task perceived to be within the control of a three year old, particularly as they grow older. This, combined with their knowledge from experience that effort is futile, may account for many young people's disengagement or at best half heartedness when engaged in treatment. Half-hearted action only increases the experience of failure, leading to frustration and perhaps to feelings of hopelessness.

Creating opportunities where effective control is possible

It is suggested that enhancing a belief in competence among young people and their parents can be facilitated when opportunities are created for them to experience effective control. In the case of bed wetting this can involve exercising control over the treatment process, although the outcome cannot be guaranteed, and minimising the effects of the practical consequences of bed wetting.

One way of increasing the experience of effective control, come upon serendipitously in this study, is to encourage young people to keep a truthful record of their wet and dry nights which is not linked to any reward for dry nights. Instead it is suggested that parents reward only the truthful and timely keeping of the record. Many parents found from their own experience that offering rewards for dry nights put too much pressure on the young person, with the result that the number of wet nights increased (Section 5.5.2). In this study several young people came to see that dry nights were possible through the keeping of the diary and the success was attributed by them to their own efforts and not to chance (Section 6.4.2). In a sense, whether the increase in the number of dry nights achieved was, in fact, due to chance does not matter. The individual's perception that the outcome was contingent on their efforts is what matters as this can lead to increased engagement with a difficult task, enhanced self esteem and optimism for the future.

If it is decided that the circumstances are right for some form of behavioural training such as a bedside or body-worn alarm, the young person should be rewarded for actively engaging in the method and keeping an accurate and timely record rather than for achieving dry nights *per se*. More dry nights may of themselves be sufficient motivation for the young person to continue with treatment once the outcome is seen to be contingent on effort.

Until the young person becomes reliably dry, it may be helpful for parents to encourage young people to take more responsibility for managing the practical consequences of the wet beds (Section 5.1.2) with a simple system of rewards or perhaps a points system leading to a special treat. This could have the added benefit of reducing the work load for the parents and the tension for everyone within the household in the mornings.

The appropriateness of this approach would need to be carefully discussed with the parents. Some parents may feel that the young person should play their part in the practicalities without the need for any tangible reward. Consistent praise may well be sufficient to convey to the young person the message: "We appreciate your help with this task" and to foster a sense of mutual co-operation. What is important is that the management of the practicalities is not portrayed as a punishment: "You wet the bed, you clear it up!"

Encouraging realistic expectations

There is evidence that the most adaptive control beliefs are realistic ones (Wannon, 1990). Malone-Lee (1992) suggests, in the context of bed wetting, that it is important not to raise false expectations of the likelihood of a successful outcome from treatment. There were many examples of unrealistic reassurance having been given to individuals in this study, as mentioned for example by Anthony:

"ANTHONY: Everyone gave me, like, an age when it would stop at. I thought, 'Oh great, it will just stop overnight when I'm that age', and of course it never did."

Anthony (age 16) 332/41 p.1

It is important for health care professionals to acknowledge to families that the attainment of night time bladder control is not an easy task for some young people and it is outwith their conscious control in most cases. The data suggest that one of the most important things that health care professionals working with families can do is to encourage parents to create a supportive social and emotional climate within the home for the young person to learn the skill of becoming dry at night. This involves them in accepting the young person as he is, acknowledging all the young person's attempts at self help, focusing on any positive gains, however small and avoiding blame.

If treatment fails it is important that the message is conveyed to families that this is not the fault of the young person or their parents if they have engaged in the treatment conscientiously as the reasons why some young people respond to certain treatments while others do not are far from certain (Chapter 2). Asking families to repeat treatment regimes which they believe do not work is doomed to failure (Section 5.6.2).

When engaged in a difficult task it is clearly maladaptive to interpret each setback as evidence of lack of ability, yet this is what most young people quite understandably seem to do. In challenging situations where active engagement is essential, people can maintain their own engagement by regulating their action, through such means as intentional self-encouragement, boosting determination, and optimism. Active engagement is facilitated by bolstering feelings of effectiveness and looking for contingencies. There are many books available on techniques to enhance "positive thinking" but positive thinking on its own is not enough. The task for health care professionals is to provide a supportive and responsive environment to ensure that family members' efforts stand the best chance of being rewarded and to encourage parents to do the same.

Enhancing a sense of competence among health care professionals

Many of the principles outlined above are equally applicable to health care professionals. The aim is to encourage health care professionals to engage with families in a difficult task for long enough for success to be achieved, to have realistic expectations and to be able to handle setbacks without resorting to disengagement. It is suggested that the confidence of health care professionals in their ability to help families could be enhanced by the availability of evidence based clinical protocols which would help them to give care known by them to meet "best practice" standards. Even the illusion of control could be adaptive, as it could motivate professionals to acquire capabilities that they do not yet possess through prolonged engagement with a challenging task.

7.4 Implications for service organisation

As this study shows, many professionals may become involved in helping families where one or more children wet the bed, including: health visitors; general practitioners; school nurses; continence nurse advisers; paediatricians; urologists; clinical medical officers; psychiatrists; clinical psychologists and social workers (Section 5.6).

Wright and Leahey (1993, p.27) stress the importance of assessing a health problem at all system levels, and then intervening at the system level "with the greatest leverage for change". If a pathological problem is suspected at the organ system level, a specialist opinion from a urologist may be pivotal to ensuring that the most appropriate care is initiated. If the problem is assessed as being exacerbated by poor interpersonal relationships within the family, then the situation may, in some cases, require the intervention of a specialist in family therapy. It is suggested, however, that for most monosymptomatic bed wetters the management of the bed wetting is well within the remit of the members of the primary health care team.

Enuresis clinics are being set up and evaluated in many parts of the UK and abroad (Chisholm, 1995; Larsen et al, 1992; Vermaak, 1992) and can provide a valuable service, but it is suggested that unless a member of the primary health care team is involved with the clinic, the context within which the bed wetting is being managed by the family may be lost sight of.

When working with pre-school children the health visitor is particularly likely to discover the family's "secret" and to be in a position to give practical advice and support to the family as a whole. Often the health visitor acts as the gatekeeper to more specialist services, via the general practitioner.

It is, however, unrealistic to expect that all health visitors will have the necessary specialist knowledge to act effectively. There is evidence to suggest that some health visitors and school nurses do not feel confident about their abilities to help families with the management of bed wetting (Paterson, 1993). In Paterson's study, a number of health visitors commented that they had received no formal education or training in this area. To quote one of Paterson's respondents:

" ... we need more training, more equipment and more expertise."

Paterson (1993) p.423

It is therefore suggested that health visitors need to be supported in this role and to receive appropriate in-service training and opportunities for up dating (Chisholm, 1995; ERIC, 1993).

The establishment of inter-disciplinary evidence based clinical protocols for assessment and treatment and the development of explicit referral criteria could increase the probability of the family gaining access to the most appropriate help. Guidelines on minimum standards of practice are already in existence (Morgan, 1993) and could be built upon.

7.5 Summary

It is shown in this study that parents and young people are likely to enter into clinical relationships with pre-conceived ideas about the causes of the bed wetting and the young person's control over the situation. In many cases these views are likely to be at variance with the views of professionals. It is suggested that a difference between lay and professional viewpoints can lead to failures of intervention, especially when family members regard the treatment suggestions of health care professionals to be ill-conceived. Failure of professionals to assess and take cognisance of the responsiveness, or otherwise, of the social environment within which their treatments are to be conducted may also lead to treatment failure. Understanding the family's perspective enables a dialogue to be engaged in which takes account of the reality of the family's circumstances, including family members' beliefs, capabilities and access to resources.

THE SERENITY PRAYER

***God grant me the serenity to accept the
things I cannot change, the courage to
change the things I can change, and the
wisdom to know the difference.***

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APPENDICES

| | |
|----------------------|--|
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YOUNG PERSON'S URINARY SYMPTOMS QUESTIONNAIRE

This questionnaire asks about any problems which your son has with passing urine in the daytime and at night. It will only take a few minutes to fill in. You may like to discuss the answers together as a family or your son may complete it unaided if preferred.

Your answers will be put together with those of other young people who wet the bed on some occasions, to build up a picture of young people's experiences.

It is entirely confidential. There is no need to put your name on it. The identification number on the top of the next page is for administrative purposes only. Your answers will only be seen by the research nurse and by the technician who enters the information on computer, who does not know who you are.

The research nurse will collect the form from you when she visits. She will be pleased to answer any questions about filling in the form when she calls.

**PLEASE ANSWER ALL THE QUESTIONS
BUT PUT A CROSS BY ANY QUESTION WHERE THE MEANING IS NOT CLEAR**

Thank you

**Moya J Morison
Research Nurse**

Study number ☐ ☐ ☐
(for computer purposes only)

PLEASE ANSWER THE FOLLOWING QUESTIONS BY TICKING THE APPROPRIATE BOX OR ANSWERING THE QUESTION IN THE SPACE PROVIDED

Section A. Night time symptoms

(Night time is from the time you go to sleep at night until the time you get up in the morning)

- 1a. how many nights in the week do you usually wet the bed?
- | | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| every night | 6 nights per week | 5 nights per week | 4 nights per week | 3 nights per week | 2 nights per week | 1 night or less per week |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 |
- b. how many nights did you wet the bed last week?
- | | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| every night | 6 nights | 5 nights | 4 nights | 3 nights | 2 nights | 1 night or less |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 |
- 2a. how many times per night do you usually wake up to find yourself wet?
- | | | | | |
|-------------------------------------|-----------------------------|----------------------------|----------------------------|----------------------------|
| once, when waking up in the morning | once, during the night only | twice | 3 times | 4 times or more |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
- b. how many times per night did you wake up to find yourself wet last week?
- | | | | | |
|-------------------------------------|-----------------------------|----------------------------|----------------------------|----------------------------|
| once, when waking up in the morning | once, during the night only | twice | 3 times | 4 times or more |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
3. on dry nights, how many times do you usually get up to use the toilet?
- | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|------------------------------|
| not at all | once | twice | 3 times | 4 times or more | I do not have any dry nights |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 |

4. have you ever had a period of at least 6 months when you were dry every night?

Yes

No

cannot remember

☐ 1☐ 2☐ 8

if YES:

b. how old were you then?

years

☐☐

months

☐☐

c. for how long (in months or years) were you dry every night?

months/years

(delete whatever does not apply)

5. when sleeping away from home with friends, relations or on holiday do you usually have:

More

Fewer

The same number

I do not sleep

dry nights

dry nights

of dry nights

away from home

☐ 1☐ 2☐ 3☐ 9

Section B. Sleeping arrangements at home

6a. do you share a bedroom with anyone else?

Yes

☐ 1

No

☐ 2

If YES, please say who you share with:

b. do you share a bed with anyone else?

Yes

☐ 1

No

☐ 2

If YES, please say who you share with:

7. what sort of bed do you sleep in? (please tick one box):

a. single bed

☐ 1

b. double bed

☐ 2

c. bunk bed, top

☐ 3

d. bunk bed, bottom

☐ 4

e. other arrangement

☐ 5

please describe here: _____

8. where is the nearest toilet in relation to your bedroom? (please tick one box):

a. next to your bedroom

☐

1

b. not next to your bedroom, but on the same floor

☐

2

c. upstairs

☐

3

d. downstairs

☐

4

e. out of doors

☐

5

f. another arrangement

☐

6

please describe here: _____

C. Day-time symptoms

(from the time you get up in the morning until the time you go to sleep at night)

| | | | | | | |
|-----------------------|------------------------------|---------------------|--------------|-----------------------|---------------|-----------------------|
| <i>Not at all</i> | <i>Very occasionally</i> | <i>Occasionally</i> | <i>Often</i> | <i>Very often</i> | <i>Always</i> | <i>Don't know</i> |
|-----------------------|------------------------------|---------------------|--------------|-----------------------|---------------|-----------------------|

In the last month, or so:

9. have you felt a strong
need to pass urine with
little or no warning?

| | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 8 |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

10. have you had to
pass urine 5-10 minutes
after you last passed urine?

| | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 8 |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

11. have you had a burning
feeling when passing urine?

| | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 8 |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

12. have you leaked urine
when coughing, sneezing,
laughing, jumping or lifting?

| | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 8 |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

13a. have you had such a strong
need to pass urine that
you leaked before being
able to reach the toilet?

| | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 8 |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

b. did the urine leak through
to the outside of your clothes?

| | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| Yes, usually | Yes, sometimes | No | Not applicable |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 9 |

c. do you wear a protective pad or
any other absorbent material in
your underpants in the daytime
in case you leak urine?

| | | |
|----------------------------|----------------------------|----------------------------|
| Yes, usually | Yes, sometimes | No |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

Q

□₂

3

8

1

 \square_2 \square_3

4

5

8

16. Please describe any other problems or practical difficulties that you have with passing urine in the daytime:

Section D - General health problems

17. do you have any health problems?

Yes ☐ 1 No ☐ 2

If YES, please briefly list the problems here:

18. are you taking any tablets, or liquid medicines at the moment?

Yes ☐ 1 No ☐ 2

If YES, please write down their names here:

Questionnaire completed by (please tick one):

a. young person, alone

☐

b. young person with one or more parents/carers

☐

c. parent(s)/adult carer(s) only

☐

THANK YOU VERY MUCH FOR YOUR HELP

YOUNG PERSON'S NIGHT TIME DIARY


















This is your diary of wet and dry nights and how often you have to get up at night to go to the toilet. It is very quick and easy to fill in.

Please - put a **B** below the clock nearest the time you go to bed

- put a **T** below the clock nearest any time when you visit the toilet during the night

- put a **W** below the clock nearest any time when you wake up wet

- put a **D** below the clock nearest when you finally get up in the morning if you are dry, or a **W** below this clock if you are wet.

| | EVENING | | | | | | | | NIGHT TIME | | | | | | | | MORNING | | | | |
|-----------|---|---|---|---|--|--|--|---|--|---|---|---|---|---|---|---|--|--|--|--|--|
| |  6pm |  7pm |  8pm |  9pm |  10pm |  11pm |  midnight |  1am |  2am |  3am |  4am |  5am |  6am |  7am |  8am |  9am |  10am | | | | |
| MONDAY | | | | | | | | | | | | | | | | | | | | | |
| TUESDAY | | | | | | | | | | | | | | | | | | | | | |
| WEDNESDAY | | | | | | | | | | | | | | | | | | | | | |
| THURSDAY | | | | | | | | | | | | | | | | | | | | | |
| FRIDAY | | | | | | | | | | | | | | | | | | | | | |
| SATURDAY | | | | | | | | | | | | | | | | | | | | | |
| SUNDAY | | | | | | | | | | | | | | | | | | | | | |

Completed by: Young person ☐ Young person with parent ☐ Other (please specify) ☐

PARENT'S/CARER'S NIGHT-TIME DIARY OF YOUNG PERSON'S BED WETTING***INSTRUCTIONS***

This is **your** diary of the young person's wet and dry nights. It also shows how often you get up during the night to help or supervise the young person because he or she has wet the bed. It is very quick and easy to fill in.

At the top of each page there is a table. In this table please mark the times you discover a wet bed and how many times in the night you get up. Below the table there is space for you to describe the night's events in a little more detail and in your own words.

There are several steps to filling in the diary:

- **Use a new sheet for EACH night,**
and fill in the day of the week and the date.
- **After the young person has gone to bed,** if he or she calls you, or you hear the bed wetting alarm at any time, please put a **C** (for called) in **row 1**, and in the same box indicate whether the bed is: wet (**W**) or dry (**D**).

Choose the box NEAREST to the time: we do not need the actual time

- **Just before you go to bed yourself,** check the young person's bed. In **row 1**, put:
W if the bed is wet or **D** if the bed is dry and
indicate the time when you go to bed with a tick (✓) in **row 2**.
- **When you get up in the morning,** check the young person's bed. Indicate if the bed is: wet (**W**) or dry (**D**), and enter this in **row 1** and
indicate the time you get up in the morning by putting a second tick in **row 2**.
- **If the young person gets up later than you, and you are still at home,** indicate whether the bed is wet (**W**) or dry (**D**) at the time when the young person gets up.
- **The next part of the diary is left blank for you to describe what happened in the night.** Who did what? How did you feel at the time? How do you feel at the time of writing up the diary?
You can continue on the back of the sheet if you need more space.
- **Please put the time when you complete the diary at the bottom of the page.** The purpose of this is to find out when people find it most convenient to describe the previous night's events in their own words.

A completed example is given on the next page. There are also two more examples for you to fill in with the research nurse. This diary method is at an early stage of development and the research nurse would like to make sure, with you, that this form of diary suits your personal circumstances. **THANK YOU FOR YOUR HELP**

EXAMPLE 1

This is what happened: At 9pm John called his mother (C) and she discovered that the bed was wet (W). She checked the bed again just before she went to bed herself, at 11.15 PM (✓) and John's bed was dry (D). John called his mother again at 2am. The bed was wet (CW). When she got up at 6.30am (✓) John's bed was wet (W) again. When John got up at 8am his bed was dry (D).

DAY OF WEEK:....Thursday.....

DATE:.....8 July.....

| | 6pm | 7pm | 8pm | 9pm | 10pm | 11pm | mid-night | 1am | 2am | 3am | 4am | 5am | 6am | 7am | 8am | 9am |
|---|-----|-----|-----|-----|------|------|-----------|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Row 1 Young person's bed wetting | | | | CW | | D | | | CW | | | | W | | D | |
| Row 2 Time you go to bed and time you get up in the morning | | | | | | ✓ | | | | | | | ✓ | | | |

The chart shows that John's mother had to get up once in the night to help him, but in total she found the bed wet three times. Below the table, she would have given in her own words more details of what happened that night.

The next two examples are for you to fill in with the research nurse

EXAMPLE 2

DAY OF WEEK:.....

DATE:.....

[illegible]

EXAMPLE 3

DAY OF WEEK:.....

DATE:.....

[illegible]

PARENTS'/CARERS' NIGHT-TIME DIARY OF YOUNG PERSON'S BED WETTING

DAY OF WEEK:..... **DATE:**.....

- CODE LETTERS:**
- W** for a wet bed
 - D** for a dry bed
 - C** young person called you
 - ✓ beneath the time you went to bed, and got up in the morning

| | 6pm | 7pm | 8pm | 9pm | 10pm | 11pm | mid- night | 1am | 2am | 3am | 4am | 5am | 6am | 7am | 8am | 9am |
|--|-----|-----|-----|-----|------|------|---------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Row 1 Young person's bed wetting | | | | | | | | | | | | | | | | |
| Row 2 Time you go to bed and time you get up in the morning | | | | | | | | | | | | | | | | |

Personal Diary

TIME OF COMPLETING DIARY:.....

MJM 8/7/93

MANAGING BED WETTING: SUMMARY OF METHODS TRIED

(Completed by research nurse in consultation with principal carer after discussion of methods tried is exhausted.)

| <i>Method</i> | <i>Have you ever used this method? (✓)</i> | <i>How old was he/she when you first tried this method? (years)</i> | <i>For how long did you try this method?</i> | <i>Are you still using this method? (✓)</i> |
|------------------------------|--|---|--|---|
| <u>BED WETTING</u> | | | | |
| <u>Enuresis alarm</u> | | | | |
| a. bedside alarm | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| type/description: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| b. body worn alarm | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| type/description: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| c. other | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (specify/description) | | | | |
| <u>Medication</u> | | | | |
| a. Desmopressin (Desmospray) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| b. Imipramine (Tofranil) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| c. Amitriptyline (Tryptizol) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| d. Other - specify (1) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (2) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |

| Method | Have you ever used this method? (✓) | How old was he/she when you first tried this method? (years) | For how long did you try this method? | Are you still using this method? (✓) |
|--|--|---|---------------------------------------|---|
| 3. <u>Modification of evening/night time routines</u> | | | | |
| a. lifting/raising to use toilet during night | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| usual time(s) of lifting: (1) _____ | | | | |
| (2) _____ | | | | |
| (3) _____ | | | | |
| b. restricting fluid <u>intake</u> | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| before bedtime | | | | |
| usual time of last drink _____ | | | | |
| usual bedtime _____ | | | | |
| c. restricting <u>type of fluid</u> taken | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| before bedtime | | | | |
| List drinks NOT given at bedtime | | | | |
| e.g. coffee, cola _____ | | | | |
| _____ | | | | |
| d. other -specify: (1) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| _____ | | | | |
| (2) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| _____ | | | | |
| 4. <u>Bedding and personal protection</u> | | | | |
| a. mattress protection methods tried: | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (1) _____ | | | | |
| (2) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (3) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| b. Personal protection worn by young person: | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (1) _____ | | | | |
| (2) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (3) _____ | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |

| <i>Method</i> | <i>Have you ever used this method? (✓)</i> | <i>How old was he/she when you first tried this method? (years)</i> | <i>For how long did you try this method?</i> | <i>Are you still using this method? (✓)</i> |
|---|--|---|--|---|
| 5. Rewards | | | | |
| a. "stars for dry nights" chart | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| b. other "incentive" chart e.g. Princess Marie's journey to the palace | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| c. other - specify (1) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (2) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| (3) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| 6. Penalties/sanctions | | | | |
| a. | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| b. | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| c. | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |

Method**Have you ever
used this method?**
(✓)**How old was he/she
when you first tried
this method?**
(years)**For how long
did you try this
method?****Are you still using
this method?**
(✓)**7a. Dry bed training**(an intensive training schedule involving
waking the child at set intervals during the night)☐can't remember/don't knowweeks/months/years☐**b. Concurrently with an enuresis alarm?**

(link to Q.1 for age, duration etc.)

☐**8a. Relaxation and self hypnosis**

e.g. "you are the boss of your bladder"

☐can't remember/don't knowweeks/months/years☐**b. Who taught this?**

(tick)

GP

☐

HV

☐

Clinical psychologist

☐

Urologist (hospital/clinic)

☐

Continence adviser

☐

Parents' own idea

☐

other (specify)

☐**9. Psychotherapy**

(with a clinical psychologist)

☐can't remember/don't knowweeks/months/years☐**10. Family therapy**☐can't remember/don't knowweeks/months/years☐**11. Other**☐can't remember/don't knowweeks/months/years☐

| Method | Have you ever used this method? (✓) | How old was he/she when you first tried this method? (years) | For how long did you try this method? | Are you still using this method? (✓) |
|---|--|---|---------------------------------------|---|
| DAYTIME WETTING | | | | |
| Bladder training | | | | |
| holding practice (eg visits toilet every hour, lengthen by 10 minutes per week until child can comfortably manage 6 times/day) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| retention control training (e.g. once a day drinks 1-1½ pints of favourite drink, reports need to void, timer set - to withhold voiding until timer rings, period lengthened over time) | <input type="checkbox"/> | <u>can't remember/don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| sphincter control exercises (stopping, counting, re-starting stream) | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| Dry pants training (Praise for dry pants before giving child attention such as an activity, meal, conversation) | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| Desensitisation techniques (with a clinical psychologist, to overcome specific fears relating to use of toilet) | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| Other methods (describe) | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <u>can't remember, don't know</u> | <u>weeks/months/years</u> | <input type="checkbox"/> |

15 August 1993

To parents and carers:

RESEARCH STUDY ON MANAGING BED WETTING

I am a postgraduate research nurse at Queen Margaret College in Edinburgh. My special interest is in the assessment and management of bed wetting in children and young adults. It is surprising, perhaps, that we know very little at the moment about how parents manage bed wetting in young people of different ages or the effects of bed wetting on the family as a whole.

Bed wetting is a very common problem - much more common than most people might think. Many methods have been used to treat bed wetting over the years but no one way has been found to be successful for everyone. I am undertaking a study of the methods families are using now and have tried in the past. I am interested to know about any practical problems that families have experienced and the effects of bed wetting on the young people themselves and on those who care for them.

In order to carry out this research I need the help of parents and carers and the purpose of this letter is to invite you to take part. This would involve you in:

- completing a simple questionnaire
- keeping a brief "diary of events" - this would include basic information such as how many nights per week the young person wets the bed and how many times you need to get up in the night yourself to help or supervise,
- a visit from me to collect the questionnaire and to have a conversation with you about the methods that you have used to manage bed wetting, whether or not these were prescribed by the doctor. It would also be helpful to have a brief conversation with the young person, if he or she is willing to take part.

This study has the approval of your GP and has been approved by the appropriate committee of Forth Valley Health Board. You will have received this letter from your Health Visitor. I will only know your name if you agree to this, and if you agree to take part in the study and return the consent form to me

It is important that you should know that the information collected will **not** have your name on it. It is **completely confidential**. Your answers will only be seen by me, the research nurse. The technician who enters the information on computer will not be given your name.

As with any research you have the right to withdraw at any time, without giving a reason. Your GP will not be told that you have withdrawn. Withdrawing from the study would not in any way affect the care that you receive, now or in the future.

If you agree to help with this research please complete the consent form enclosed and return it to me in the envelope provided.

If you have any questions about the study please do not hesitate to contact me, by writing to me at the above address or telephoning me at the following number:

0786 842034.

Should I be out of the office, please leave a message on the answerphone and I will return your call. This telephone line is for my use only, and no-one else will hear your call.

Your help by participating in this study would be greatly appreciated. I hope that through your participation new knowledge will be gained which will be very useful in helping both nurses and doctors to understand bedwetting from the carers' point of view, and benefit those who experience bed wetting in the future. Many people find that they themselves benefit from taking part in a study such as this by talking through experiences with someone who is outside the family and who is not directly involved in their care.

Yours sincerely

Moya J Morison



Arwood Terrace • Edinburgh • EH12 8TS

Telephone 031 317 3000
Fax No 031 317 3256

To: **Mrs Moya Morison**
Post graduate Research Nurse

Health and Nursing
Head of Department
Prof W W Thomson BSc (Soc Sci),
RGN, SCM, ONC, DipNAdmin, RNT

RESEARCH ON MANAGING BED WETTING

CONSENT FORM

To be completed by parent or principal carer and by the young person if aged 16 years or over

I confirm that I am willing to take part in this research.

The purpose of the study has been explained to me in writing. I understand that I may withdraw from the study at any time without giving a reason. My GP will not be informed of my decision.

Signature of parent
or principal carer:

Date:.....

Please PRINT name:.....

Relationship to young person (if not parent):.....

Signature of young person
(if aged 16 years or over):.....

Date:.....

Please PRINT name:.....

Please complete this part of the form in BLOCK CAPITALS

ADDRESS:
.....
.....
.....
.....

Telephone number (if available):.....

Best time for research nurse to telephone you to arrange to meet:.....

THANK YOU FOR YOUR HELP

HOW MANY SUBJECTS WILL PARTICIPATE? Justify sample size

It is hoped initially to recruit 25 families from all occupational classes to the main study, with individuals evenly distributed across the age range and from both sexes. Because of the sensitivity of the topic a response rate of only 50% may be realistic. Allowing 5-6 families for pilot interviews contact may need to be made with 50-60 families initially. This is an exploratory study involving a grounded theory approach which is intended to identify the variables relevant to the study's research questions. As such it involves in-depth interviews with relatively small numbers of families. Families will be recruited until the variation within the sample has been explained.

WHAT ARE THE CRITERIA FOR SUBJECT PARTICIPATION/EXCLUSION?

Inclusion criteria: families with one or more young persons aged 5-20 years, living at home, who have primary or secondary nocturnal enuresis and who experience at least 7 wet nights in a two-week period.

Exclusion criteria: families where the young person with nocturnal enuresis is sufficiently mentally or physically ill or handicapped to be attending a special school or day care facilities for the mentally or physically ill or handicapped, or to be receiving care exclusively at home.

HOW ARE SUBJECTS TO BE SELECTED?

The sample will be selected from families known to the GP and Health Visitor and from outpatients attending urodynamic/continence clinics referred to the Continence Advisory Nurse. In order not to breach confidentiality or to jeopardise relationships between the family and the GP, Health Visitor and Continence Adviser, a letter (Appendix V in this thesis) inviting families to participate in the study, will be sent direct to the families from their Health Centre or delivered by the Health Visitor, with a reply-paid envelope addressed to the researcher. In this way, the researcher will only know the identities of those families who have given their informed consent. Families who decline to take part will not be followed up but the number of refusals will be noted to calculate the overall response rate.

HOW LONG WILL INDIVIDUAL SUBJECTS BE INVOLVED IN THE STUDY?

The main data collection phase for each family is expected to be complete within 3 months. This is the time from the initial approach requesting the family's permission to take part in the study to the completion of diaries and interviews with the research nurse. At a later date, approximately 9 months after the initial contact, the research nurse will return to the family briefly with the aggregated study results.

NHS FACILITIES TO BE USED IN THE COURSE OF THE STUDY

Where appropriate, approval/agreement for use should be detailed.

None

HOW WILL THE CONSENT OF OTHERS CLINICALLY INVOLVED, INCLUDING SUBJECTS' GPs, BE OBTAINED?

The appropriateness of the method in relation to its aims and the practicalities of this study have been discussed with Mr A, Chief Nurse Adviser and Director of Quality (HB); Mrs B, Senior Nurse; Miss C, Director of Nursing Services and Quality; with members of the GP Research Group, and with a senior consultant urologist.

The subjects' GPs will be sent a copy of this application and a complete set of the study papers and protocol as appended here, including the letter to families, consent form and all questionnaires, together with a consent form for them to complete, agreeing to their patients taking part. Meetings will then be held with the Health Visitors of the practices being approached to explain the purpose of the study and its conduct.

SAMPLE SELECTION FORM *STUDY ID NUMBER ☐☐☐Health Centre:..... H/V will: a. post letter to family(1) unannounced ☐

Health Visitor:.....

(2) after telephoning first ☐(3) family already aware of study ☐

Date:.....

b. deliver letter by hand at next visit ☐**INCLUSION/EXCLUSION CRITERIA****A. Young person with nocturnal enuresis**

1. Is the young person with nocturnal enuresis sufficiently mentally or physically ill or handicapped to be: a. attending a special school or day care facilities for the YES NO
mentally or physically ill or handicapped? or ☐ ☐

b. receiving care exclusively at home? ☐ ☐

If YES, nature of illness or handicap:.....

If NO, continue to questions 2-6

2. How old is the young person?

3. Personal code number:

| | | |
|--------------------------|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (male/female) | d d m m y y | initials |
| | (DATE OF BIRTH) | (first name/surname) |

4. Is the young person living at home? YES ☐ NO ☐

5. How many nights per week, on average, does the young person wet the bed?

B. Family composition

6. Which adults is the young person living with? (circle as appropriate):

a. parents: natural mother natural father partner (female) partner (male)

b. other adults: grandmother grandfather aunt uncle

other (specify):.....

7. How many other young people are there in the household?

What are there ages/sex?.....

* Completed by researcher

FACES - FEELINGS CARD TEXTS¹

Here are some faces expressing various feelings



Which face comes closest to expressing:

1. how you feel about bed wetting



2. how you feel when you wake up and find that the bed is wet



3. how you feel about the practical side of managing a wet bed (changing the sheets, changing yourself and so on)



¹ These cards were individually laminated, cleanable and reusable
The texts for four cards are illustrated above

FACES - FEELINGS CARDS
TEXTS FOR REMAINING CARDS

Which face comes closest to expressing:

4. **how you think your mother feels about you wetting the bed**
5. **how you think your mother feels about the practical side of managing a wet bed (changing and washing sheets and so on)**
6. **how you think your father feels about you wetting the bed**
7. **how you think your brothers/sisters feel about you wetting the bed**
8. **how you think your special friends feel about you wetting the bed (of those who know)**
9. **how you feel about staying overnight with friends (whether or not you ever stay away over night just now)**
10. **how your mother feels about you staying overnight with friends**
11. **how you feel about yourself**
12. **how you feel about life as a whole**

Which face comes closest to expressing how you feel about taking part in this study

APPENDIX IX An example of a memo written by the researcher to herself during an early phase of data collection to record ideas about an emerging concept:

" Putting the significance of health care professionals' input into perspective

- families may contact hcps¹ only once (we don't know how many never do, of course)
 - ± success subsequently?
 - hcp¹ back to family by chance e.g. for a developmental check for a younger child and discover - 8 months later - that the problem still exists
- hcp's¹ own feelings of helplessness - not having much to offer
- parents quickly recognise that hcps¹ don't have a magic way of "fixing it" - yet who else do they turn to if professionals can't help?
- "we've been through all that..."
- families may feel reluctant to call in the HV because of the "stigma" - the HV being seen to call (is this a social class related concept? - isolation of I and II vs "community" of IV and V - being around more?) "

Note:

¹ hcp(s) = health care professional(s)

APPENDIX X An example of a "story line" (a general descriptive overview reflecting thinking about the study at a point in time) written at an early stage of data analysis to facilitate the identification and integration of emerging concepts

"This story is about how parents and young people manage nocturnal enuresis and the impact of nocturnal enuresis on individuals living within the family home.

Unless unavailable through chronic illness or work commitments, the mother acts as orchestrator:

- *managing the immediate consequences of nocturnal enuresis*
- *managing treatment, and*
- *managing other people - her partner*
 - *other family members (young persons' siblings, her own brothers)*
 - *other adults (baby sitters, her friends, young person's teachers)*
 - *health care professionals.*

This occurs within the context of the mother's wider role as child carer within the family unit, with the father acting in a supporting role.

The orchestrator, whether mother or father, sets the tone for the management of bed wetting, and creates the environment for the young person to learn the skill of becoming dry at night. The orchestrator does this consciously through the line or strategy that they choose to adopt and unconsciously through their attitude to the young person and the young person's bed wetting, and their personal interactional style (their mode of expressing thought in language).

The orchestrator's attitude to the young person and to their bed wetting is affected by:

- *their personal philosophy, values and beliefs - in particular about parenting*
- *their previous personal experience of bed wetting within their immediate family*
- *the presence of concurrent stressors which interfere with the easy management of the practical consequences of nocturnal enuresis (wet sheets etc.)*
- *other consequences of the young person's bed wetting for them and for other family members (e.g. frustration, strain, interference with sleep and thence interference with the next day's activities)*
- *their perception of the extent to which the young person can control the phenomenon.*

The management methods that parents try reflect their current hypothesis (provisional explanation) of the cause of the young person's bed wetting. As each hypothesis is tested and ruled out the search for an alternative explanation continues. Many factors affect the intensity of the search, especially others' expectations that the child should now be dry (formally at transition times such as pre-school checks, when the mother may be made to face the fact that her child has not reached a developmental milestone "normal" for a child at that age, or when moving to secondary school and informally through the remarks of other family members, friends and acquaintances).

Both parents' attitudes to the young person's bed wetting change over time. As other possible causes are progressively discounted both parents come to believe that the young person could control and eventually stop bed wetting if they made the effort. The mother's feelings of protectiveness towards the young person may however, be very tenaciously held, even into the young person's teenage years, leading to a strategy dilemma and conflict with her male partner. As the child gets older, parents question whether they have adopted the right strategy in the past (have they been too "soft?") and become increasingly disillusioned with health care professionals' ability to help to resolve the problem. They may turn to complimentary medicine if they believe in and can afford this.

Young people have a uniformly negative perception of their parents' feelings about their bed wetting - however positive and supportive a strategy the parents are endeavouring to sustain. While feeling happy about life in general, the young person's self image is adversely affected by a parent's unsympathetic, punitive attitude towards them. Young people want their bed wetting to cease and feel saddened, embarrassed and ashamed about it. Their belief in their ability to control their bed wetting lessens as a result of the continued failure of each new method tried to deliver the desired outcome of a reliably dry bed, while their parents' belief that they can help it grows with the young person's increasing age.

The young person may be hindered in learning to become dry at night by deficiencies in the parents' training competency, which may in turn be affected by insufficiently well informed and continuing support from health care professionals."

APPENDIX XI Steps involved in data handling, storage and retrieval using the NUD•IST Power Version 3.0 programme
(See also Figure 5 for an overview of the process, Table 4 for the definitions of some technical terms and Sections 3.9.2 and 3.9.3 for an explanation of the nature and purposes of the indexing system)

A. Conversations transcribed using a word processor

1. Transcripts were checked for accuracy by the researcher against audio tapes of the conversations with families and corrections were made.
2. Each family member was assigned a unique identifying sequence of letters, e.g. MRS ABC, the data were split into text units (a sentence, paragraph, or interaction sequence, according to meaning) and the speaker's identification added to each text unit.
3. Corrected transcripts were checked again for accuracy and converted to "text only" files (that is, they were stripped of all but internationally used word processing commands so that they were in a form suitable for importing into NUD•IST).



B. Data imported into NUD•IST

4. 62 transcripts were imported as text only "raw files" and placed into a NUD•IST indexing tree called "families" (Figure 4, node 6) e.g. all data from members of Mrs ABC's family were put into node 6 1, from Mrs DEF's family into node 6 2 and so on.
5. The raw files were searched for the individual's unique identification, e.g. MRS ABC (this is a "string" search).
6. All data found for one individual were placed into the individual's data node. e.g. Mrs ABC's conversational data were put into node 7 1 (Figure 4). Her daughter's conversational data were put into node 7 2 and so on.
7. The same search results were put into each of the relevant base data nodes to facilitate sorting subsequently.





C. Indexing attached to text units and references to these text units placed into the hierarchical indexing system

8. The transcripts were first open coded (Section 3.9.2).
9. Over a 1 year period a set of hierarchical coding or "indexing" trees was developed composed ultimately of 888 nodes where references to text units were put (see Figures 4, 7 and 8, for overall structure of indexing tree and some examples of indexing).
10. The imported text units were each assigned index codes.
11. A rigorous account was kept of the processes involved in data handling for each family's data.



D. Indexing system searched and data retrieved according to specified search parameters

12. The indexing system was searched for the occurrence or co-occurrence of themes (Section 3.9.3, Figure 6 and Appendix XII).
13. The results of the searches were kept as reports (454 in total) and printed off. Some were re-imported into the indexing tree.
14. The reports relating to a particular theme were then re-analysed.
15. The relationships between emerging concepts were tested using more sophisticated searches for co-occurrence (Appendix XII).

APPENDIX XII

Descriptions of the search and sort facilities of NUD•IST used most frequently in this study to explore the data (based on Richards and Richards, 1994) (see Figure 6 for the full range of operating commands)

| <u>Operator</u> | <u>Search Command</u> | <u>Explanation of what is done</u> |
|--|---|--|
| A. <u>Collating operators</u> | | |
| Intersect | (intersect (6 1 3) (4 2) (7 2 2 4)) | Finds all text units indexed by <i>all</i> of the given set of two or more nodes. |
| Union | (union (6 1 3) (7 2 2 4)) | Finds all text units indexed by <i>any</i> of the given set of two or more nodes. |
| Less | (less (6 1 3) (4 2) (7 2 2 4) (5 3 1)) | Finds all text units indexed by the first mentioned node (6 1 3 here) <i>but not</i> by any of the other (one or more) given nodes. |
| B. <u>Negation operator</u> | | |
| Not-in | (not-in (6 1 3)) | Finds units not indexed by the named node. |
| C. <u>Restrictive operators</u> | | |
| Including-docs-from | ((6 1 3) including-docs-from (4 2)) | Includes index references for the first node, but restricted to documents indexed by the second node. |
| Excluding-docs-from | ((6 1 3) excluding-docs-from (4 2)) | Includes index references for the first node, but excludes documents indexed by the second node. |
| D. <u>Taxonomic Tree</u> | | |
| <u>Structure operators</u> | | |
| Inherit | (inherit (5 1 3 4)) | Merges (unions) all the index references in the 'ancestor' nodes of the given node - the ones above it in the path from it up to the root of the index system. Here, it unions index references in (5), (5 1) and (5 1 3). |

| <u>Operator</u> | <u>Search Command</u> | <u>Explanation of what is done</u> |
|---|------------------------------------|---|
| D. (continued) Collect | (collect (6 3)) | <p>Merges (unions) all the index references at the node and at all nodes in the subtree below it. Suppose the nodes below (6 3) are (6 3 1), (6 3 1 4), (6 3 2), (6 3 2 2), and (6 3 2 3). Then a Collect on (6 3) will union the index references in all six of the nodes. This can be very useful for studying all material about a general concept, including material indexed at more specific concepts below it.</p> |
| E. <u>Matrix-constructing operators</u> Matrix | (matrix intersect (6 1) (1 1 2)) | <p>Takes all the children of the first-named node, - (suppose they are (6 1 1), (6 1 2), (6 1 3), (6 1 4) and (6 1 9)); and all the children of the second-named node, - suppose they are (1 1 2 1), (1 1 2 2) and (1 1 2 3); and applies the named operator (such as Intersect) in pairs to one of the first group with one of the second group). The result is a <i>Matrix</i>. A report on the node (made using Investigate node in the IndexSystem menu, Figure 6) lists the requested information for each cell in the matrix.</p> |
| Vector | (vector intersect (6 1 1) (1 1 2)) | <p>Like Matrix, except the operator is applied in pairs to the first node address itself (not its children) and the children of the second node address</p> |

APPENDIX XIII Summary of contextual data relating to each family

| Pseudonym of the young person who wet the bed | Age of young person | Parents currently living within the household | | | | No. of times family reordered ^b | Relative deprivation of the electoral ward where the family lives ^c | | | Parent's experience of bed wetting | | | | |
|---|---------------------|---|----------------|-------------|-----------------------|--|--|------------------------|-------------------------|------------------------------------|------------------|------------------------|--------------------|-------------------------------|
| | | Natural mother | Natural father | Step father | Mother's male partner | | Most affluent quartile | Intermediate quartiles | Least affluent quartile | Mother herself | Mother's sibling | Natural father himself | Stepfather himself | Mother's male partner himself |
| Carol | 17 | ✓ | | | ✓ | 2 | | | ✓ | ✓ | NK | ✓ | | NK |
| Anthony | 16 | ✓ | ✓ | | | 0 | | ✓ | | | X | X | | |
| Peter | 15 | ✓ | | ✓ | | 2 | ✓ | | | | ✓ | X | | |
| Roger | 14 | ✓ | ✓ | | | 0 | | | ✓ | | X | X | | |
| Paul | 13 | ✓ | ✓ | | | 0 | | ✓ | | | ✓ | X | ✓ | |
| Ian | 13 | ✓ | ✓ | | | 0 | | ✓ | | | ✓ | X | | |
| Sarah | 11 | ✓ | ✓ | | | 0 | | ✓ | | | ✓ | X | | |
| Jennifer | 9 | ✓ | | | | 1 | | | ✓ | | X | X | | |
| Alison | 9 | ✓ | | ✓ | | 2 | | | ✓ | | ✓ | X | NK | |
| Tracy | 9 | ✓ | | | | 1 | ✓ | | | | X | X | | |
| William | 9 | ✓ | | | ✓ | 2 | | ✓ | | ✓ | ✓ | X | | X |
| Michelle | 8 | ✓ | | ✓ | | 2 | | ✓ | | | ✓ | X | X | |
| Simon | 8 | ✓ | | ✓ | | 2 | ✓ | | | | X | X | X | |
| Stephen ^a | 8 | ✓ | | | | 1 | | ✓ | | | ✓ | | | |
| John ^a | 8 | ✓ | | | | 1 | | ✓ | | | ✓ | | | |
| Michael | 8 | ✓ | ✓ | | | 0 | ✓ | | | | X | X | | |
| Shelly | 7 | ✓ | ✓ | | | 0 | | | ✓ | | X | X | | |
| Martin | 6 | ✓ | ✓ | | | 0 | | ✓ | | | X | X | X | |
| Gary | 5 | ✓ | ✓ | | | 1 | | | | | X | X | X | |
| Lisa | 4 | ✓ | ✓ | | | 0 | | | ✓ | | X | X | X | |

Notes: ✓ = YES X = NO NK = not known NA = not applicable

a twins b see Section 4.2 c see Section 4.1

APPENDIX XIV

Summary of each young person's night and day time urinary symptoms

| Pseudonym | Age | Primary (P) or Secondary (Sec) bed wetting | Ever dry at night ^a (Yes/No) | Frequency of bed wetting (nights/week) | | | Daytime urinary symptoms | | | | Current Medication ^j | Frequency pre medication ^k | |
|-----------|-----|--|---|--|-----------|---------------------|--------------------------|------------------------|-----------------------|--------------------|---------------------------------|---------------------------------------|------------------------|
| | | | | Questionnaire ^{b1} | | Diary ^{b2} | Daywetting | | Urgency ^{b1} | | | | |
| | | | | Usual | Last week | | Now ^{b1} (Y/N) | At school ^g | | (Y/N) ^h | | | Often/Very Often (Y/N) |
| | | | | | | | | Recent | Ever | | | | |
| Carol | 17 | P | No | 7 | 6 | 5 | Yes ^{ef} | Yes | Yes ⁱ | Yes | I | | |
| Anthony | 16 | P | No | 6 | 2 | 2 | Yes ^c | | Yes | No | NA | | |
| Peter | 15 | P | No | 6 | 6 | 5 | Yes ^d | | | No | NA | D | |
| Roger | 14 | P | No | ≤1 | ≤1 | 0 | Yes ^c | | Yes ^c | No | NA | D | |
| Paul | 13 | P | No | 3 | 5 | <1 | No | | | No | NA | | |
| Ian | 13 | P | No | ≤1 | ≤1 | 1 | No | | | No | NA | D | |
| Sarah | 11 | P | Yes | 6 | 6 | 5 | Yes ^c | | | No | NA | D | |
| Jennifer | 9 | P | No | 4 | 3 | 3 | Yes ^c | | | Yes | No | | |
| Alison | 9 | P | Yes | 7 | 7 | 2 | Yes ^{ef} | | Yes | Yes ⁱ | Yes | | |
| Tracy | 9 | P | No | 5 | 5 | NK | Yes ^c | Yes ^c | | Yes | No | | |
| William | 9 | P | No | 3 | 2 | 3 | Yes ^c | | | No | NA | | |
| Michelle | 8 | P | Not Kn | ≤1 | ≤1 | NK | No | | | Not Kn | NA | | |
| Simon | 8 | P | No | 2 | 2 | NK | Yes ^c | Yes | Yes | No | NA | D | |
| Stephen | 8 | Sec | Yes | 7 | 7 | 6 | Yes ^{ef} | Yes ^c | | No | NA | | |
| John | 8 | Sec | Yes | 3 | ≤1 | 2 | No | | | No | NA | | |
| Michael | 8 | Chronic renal failure | No | 7 | 7 | 7 | Yes ^{df} | Yes | Yes | Yes | No | S | |
| Shelly | 7 | P | No | 7 | 7 | 5 | Yes ^d | Yes ^c | | No | NA | | |
| Martin | 6 | P | Yes | ≤1 | ≤1 | 0 | No | | | Not Kn | NA | T | |
| Gary | 5 | Sec | Yes | 7 | 7 | NK | Yes ^{df} | Yes | | Not Kn | Not Kn | | |
| Lisa | 4 | P | Yes | 7 | 7 | 6 | Yes ^{ef} | Yes | Yes | Yes | Yes | | |

NOTES:

- a see Section 4.3.2
- b1 data from urinary symptom questionnaire (Appendix I)
- b2 data from young person's/parent's diaries (Appendices II and III) NK = diary not kept and frequency not known
- c very occasionally
- d occasionally
- e very often
- f leakage of urine to outside of clothes (sometimes/usually)
- g from conversation with parents or young person
- h definition of urgency: young person can wait comfortably for less than 1 minute from first feeling the need to pass urine to going to the toilet
- i possible unstable bladder, according to an independent opinion from a senior consultant urologist on reviewing urinary symptom questionnaire as a whole
- j current medication for bed wetting:
 - D = Desmospray
 - I = Imipramine
 - S = Stohl's solution and Alfalcidol
 - T = Triptizol
- k frequency of bed wetting (nights per week), as reported by parents pre-medication

APPENDIX XV Disturbance at night time for young people and their parents, related and unrelated to bed wetting

| Disturbance at night time for young people and their parents related and attributed to bed wetting | | | | | | | | | | | | |
|--|---|---|------------------|-----------------------|--|---------------------------------------|-------------------------|--|-----------|---|-------------|---------------|
| A G E | USUAL FREQUENCY OF WET NIGHTS PER WEEK ^c | NUMBER OF TIMES PER NIGHT YOUNG PERSON: | | | GETS UP TO TOILET ON DRY NIGHTS ^c | DURING DIARY KEEPING ^d | | | | PARENT LIFTING YOUNG PERSON AT PARENT'S BED TIME ^e | | |
| | | WAKES UP WET ^a | | 2-3 TIMES IN NIGHT | | NUMBER OF NIGHTS DIARY KEPT | NUMBER OF WET NIGHTS | NUMBER OF NIGHTS MOTHER DISTURBED AFTER SHE HAD GONE TO BED | CURRENTLY | EVER | | |
| | | ONCE IN MORNING | ONCE IN NIGHT | | | | | | | | FOR WET BED | OTHER REASONS |
| CAROL | 7 | | ✓ | | 0 | PARENT'S DIARY NOT KEPT BY AGREEMENT | | | | | | ✓ |
| ANTHONY | 6 | ✓ | | | 0 | 27 | 9 | 0 | 0 | | ✓ | |
| PETER | 6 | ✓ | | | 0 | 21 | 14 | 0 | 0 | | ✓ | |
| ROGER | 51 | ✓ | | | 1 | 28 | 0 | 0 | 0 | | ✓ | |
| PAUL | 3 | ✓ | | | 1 | DIARY NOT KEPT, BUT A RECORD WAS KEPT | | | | | | ✓ |
| IAN | 51 | ✓ | | | 0 | 18 | 3 | 0 | 0 | | NK | |
| SARAH | 6 | ✓ | | | 1 | 21 | 15 | 0 | 0 | | ✓ | |
| JENNIFER | 4 | ✓ | | | 0 | 28 | 13 | 0 | 1 | | ✓ | |
| ALISON | 7 | ✓ | | | 2 | 28 | 10 | 0 | 4 | | ✓ | |
| TRACY | 5 | ✓ | | | 2 | DIARY NOT KEPT | | | | | | ✓ |
| WILLIAM | 3 | ✓ | | | 1 | 27 | 12 | 4 | 3 | ✓ | ✓ | |
| MICHELLE | 51 | | | ✓ | 1 | DIARY NOT KEPT | | | | | | ✓ |
| SIMON | 2 | ✓ | | | 1 | PARENT'S DIARY NOT KEPT BY AGREEMENT | | | | | | ✓ |
| STEPHEN ^a | 7 | ✓ | | | 0 | 23 | 21 | 0 | 0 | | ✓ | |
| JOHN ^a | 3 | | ✓ | | 0 | 23 | 8 | 0 | 0 | | ✓ | |
| MICHAEL ^b | 7 | | ✓ | | NA | 27 | 27 | 27 | 0 | ✓ | ✓ | |
| SHELLY | 7 | ✓ | | | 0 | 28 | 22 | 1 | 7 | | ✓ | |
| MARTIN | 51 | | | ✓ | 1 | 23 | 0 | 0 | 0 | | ✓ | |
| GARY | 7 | | | ✓ | 0 | DIARY NOT KEPT | | | | | | |
| LISA | 7 | | | ✓ | 2 | 28 | 26 | 14 | 0 | ✓ | ✓ | |

Notes: NK = NOT KNOWN; NA = NOT APPLICABLE; ^a twins; ^b has chronic renal failure; ^c source of data is urinary symptom questionnaire; ^d source of data is mother's diary; ^e source of data is conversations with parents